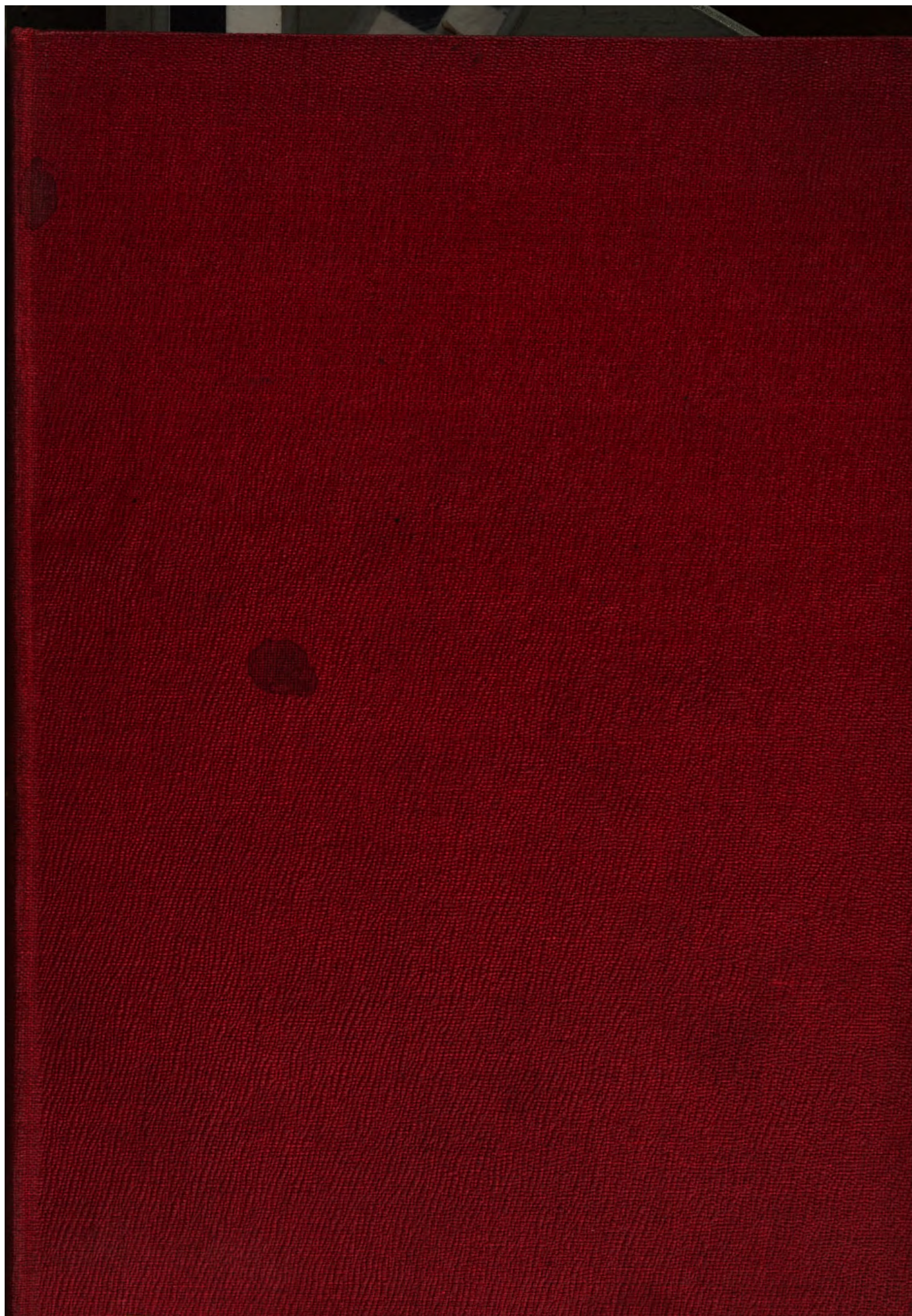
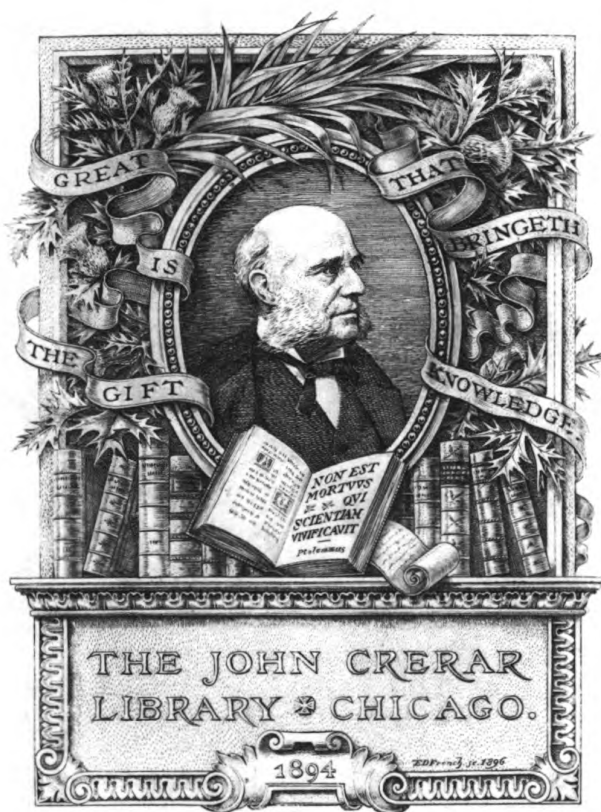
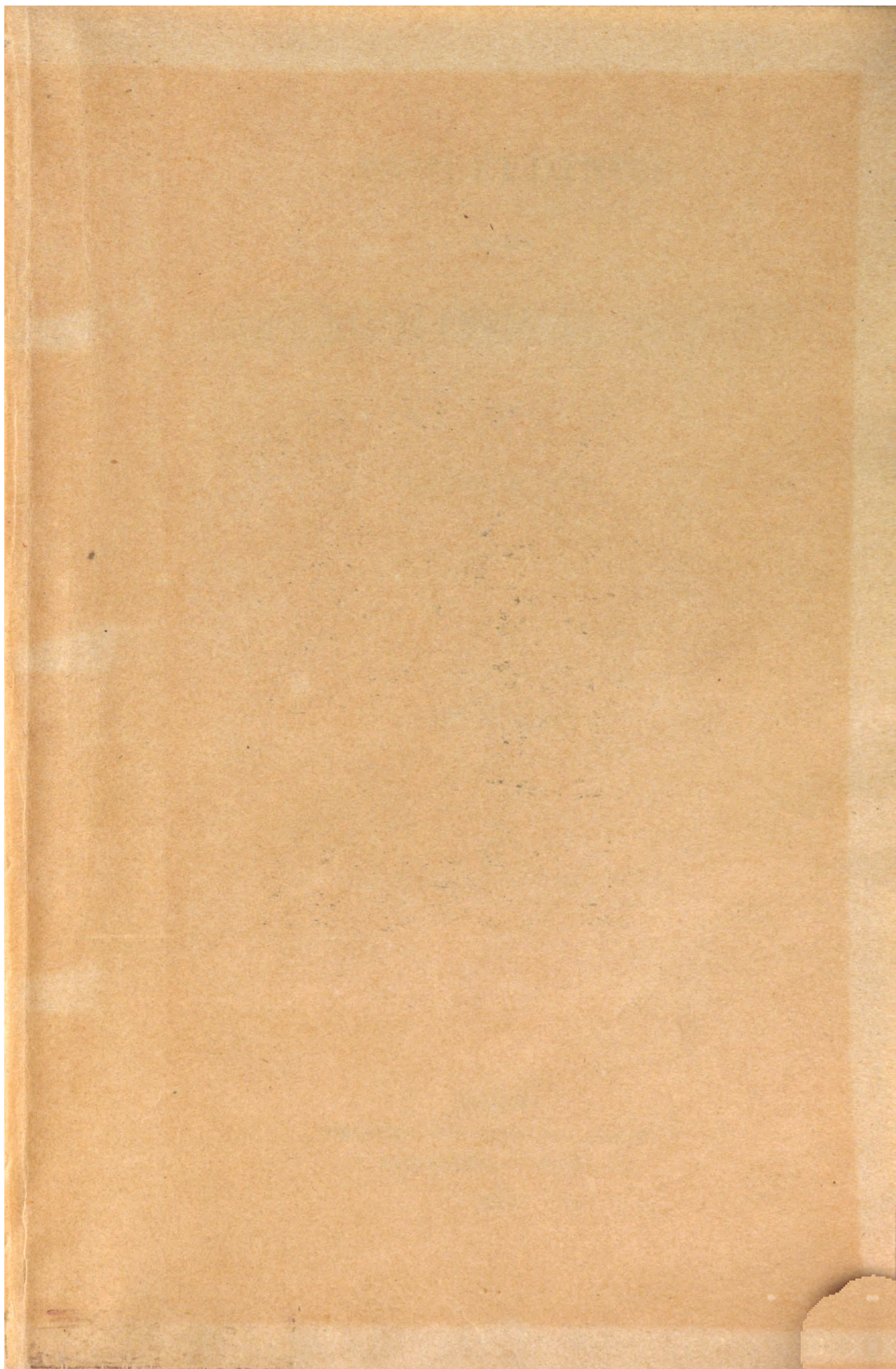








752

THE
PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY
OF THE
LONDON.

VOL. XIII.
1905—1906.

PL

WITH
LIST OF OFFICERS, MEMBERS, ETC.

London:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.
—
1906.

201
HARBOUR
VARIABLE

OFFICERS AND COUNCIL
OF THE
Laryngological Society of London

ELECTED AT
THE ANNUAL GENERAL MEETING,
JUNE 1st, 1906.



President.

J. B. BALL, M.D.

Vice-Presidents.

WILLIAM HILL, M.D. CHARTERS J. SYMONDS, M.S.
P. WATSON-WILLIAMS, M.D.

Hon. Treasurer.

H. BETHAM ROBINSON, M.S.

Hon. Librarian.

STCLAIR THOMSON, M.D.

Hon. Secretaries.

H. J. DAVIS, M.B. W. JOBSON HORNE, M.D.

Council.

SIR FELIX SEMON, K.C.V.O., M.D. J. MIDDLEMASS HUNT, M.B.
PHILIP DE SANTI. S. PAGET.
ATWOOD THORNE, M.B.

The above form the Council.

PRESIDENTS OF THE SOCIETY.

(From its Foundation.)

ELECTED

1893	SIR GEORGE JOHNSON, M.D., F.R.S.
1894-6	SIR FELIX SEMON, K.C.V.O., M.D., F.R.C.P.
1897-8	H. TRENTAM BUTLIN, F.R.C.S.
1899-1900	F. DE HAVILLAND HALL, M.D., F.R.C.P.
1901-2	E. CRESSWELL BABER, M.B.
1903-4	P. MCBRIDE, M.D., F.R.C.P.ED.
1904-6	CHARTERS J. SYMONDS, M.S., F.R.C.S.
1906-7	J. B. BALL, M.D.

THE MORBID GROWTHS COMMITTEE

FOR THE YEAR 1906.

•

WALTER SPENCER, F.R.C.S. (*Chairman*).

WYATT WINGRAVE, M.D.

LAMBERT LACK, M.D.

E. B. WAGGETT, M.B. (*Hon. Sec.*).L. H. PEGLER, M.D. (*Curator*).

LIST OF EXCHANGES.

PERIODICALS :

The Journal of Laryngology, Rhinology, and Otology (London).
 Archiv für Laryngologie (Berlin).
 Revue Hebdomadaire de Laryngologie, etc. (Bordeaux).
 Archivi Italiani di Laringologia (Naples).
 Annales des Maladies de l'Oreille, du Larynx, etc. (Paris).
 Bollettino delle Malattie dell' Orecchio, etc. (Florence).
 The Laryngoscope (St. Louis, U.S.A.).
 Monatsschrift für Ohrenheilkunde, etc.
 Archivio Italiano di Otologia (Turin).
 Archives Internationales de Laryngologie, Otologie, et Rhinologie (Paris).
 La Parole (formerly Revue de Rhin., Otol., et Laryn.).

TRANSACTIONS OF THE FOLLOWING SOCIETIES :

British Laryngological, Rhinological, and Otological Association.
 American Laryngological Association.
 American Laryngological, Rhinological, and Otological Society.
 Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte.
 New York Academy of Medicine, Section of Laryngology.
 Wiener Laryngologische Gesellschaft.
 Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.
 Laryngologische Gesellschaft zu Berlin.
 Medical Society of London.
 Brighton and Sussex Medico-Chirurgical Society.

HONORARY MEMBERS.

FRAENKEL, Professor B., 4, Belle Vue Strasse, Berlin, N.W.
KILLIAN, Professor G., 39, Friedrichstrasse, Freiburg-in-Breisgau.
LEFFERTS, G. M., 212, Madison Avenue, New York, U.S.A.
LERMOYEZ, M., 206, Boulevard Haussmann, Paris.
MASSEI, Professor, 4, Piazza Municipio, Naples, Italy.
MOURE, E. J., 25bis, Cours du Jardin Publique, Bordeaux.
SCHMIDT, Professor **MORITZ**, Frankfort-on-the-Main, Germany.
SCHMIEGELOW, Professor E., 18, Norregarde, Copenhagen.
v. SCHRÖTTER, Professor, 3, Marianengasse I, Vienna.
SOLIS-COHEN, J., 1431, Walnut street, Philadelphia, U.S.A.
WALKER, **THOMAS J.**, M.D., Peterborough.

DECEASED HONORARY MEMBERS.

GARCIA, **MANUEL** . . . Died 1906.
JOHNSON, **SIR GEORGE** . . . Died 1896.
MEYER, **HANS WILHELM**, M.D. . Died 1895.
SCHECH, Professor P. . . . Died 1905.
STÖRK, Professor Died 1899.

Laryngological Society of London.

LIST OF MEMBERS,

1906.

EXPLANATION OF ABBREVIATIONS.

Indicating Past or Present Officers of the Society.

(P.) PRESIDENT.	(L.) LIBRARIAN.
(V.-P.) VICE-PRESIDENT.	(S.) SECRETARY.
(T.) TREASURER.	(C.) COUNCILLOR.
(O.M.) ORIGINAL MEMBER.	

N.B.—Members are reminded that they are, themselves, responsible for the correctness of the descriptions in the following lists, and it is particularly requested that any changes of title or residence may be communicated to the senior Secretary.

Members who pay their Annual Subscription through a Banker's Order (to be obtained from the Treasurer) have an asterisk prefixed to their names.

LONDON.

Elected.

- 1899 ABERCROMBIE, PETER, M.D. Glasg., 56, Harley street, W.
 1899 AGAR, MORLEY, 68, Wimpole street, W.
 1893 *AIKIN, WILLIAM ARTHUR, M.D., 66, Bedford gardens, Kensington, W.
 1893 AYRES, CHARLES JAMES, M.D., 55A, Welbeck street, Cavendish square, W.
 O.M. BABER, EDWARD CRESSWELL, M.B., 62, Brook Street, W.
 C. V.-P. P.
 O.M. BALL, JAMES BARRY, M.D., 12, Upper Wimpole street, W. C. V.-P. P.
 1905 BARWELL, HAROLD SHUTTLEWORTH, M.B., F.R.C.S., 55, Wimpole Street, W.

Elected.

- O.M. BEALE, EDWIN CLIFFORD, M.A., M.B., F.R.C.P., 23, Upper Berkeley street, W. S. L. T. V.-P.
- O.M. *BOND, JAMES WILLIAM, M.D., 26, Harley street, W. C. V.-P.
- O.M. BOWLBY, ANTHONY ALFRED, C.M.G., F.R.C.S., 24, Manchester square, W. C. V.-P.
- O.M. BUTLIN, HENRY TRENTAM, F.R.C.S., 82, Harley street, W. T. P.
- 1900 CARSON, H. W., F.R.C.S., 26, Welbeck street, W.
- 1895 CATHCART, GEORGE C., M.B., C.M., 35, Harley street, Cavendish square, W.
- 1895 *CHEATLE, ARTHUR H., F.R.C.S., 18, Savile row, W.
- 1903 COBBLEDICK, ARTHUR STANLEY, M.D., 402, Brixton road, S.W.
- 1893 COLBECK, EDMUND HENRY, M.A., M.D., F.R.C.P., 55, Upper Berkeley street.
- 1899 COLLIER, M. P. MAYO, F.R.C.S., 145, Harley street, W.
- 1894 *CRIPPS, CHARLES COUPER, M.D., 195, Camberwell grove, S.E.
- O.M. *CRISP, ERNEST HENRY, 43, Fenchurch street, E.C.
- 1899 DAVIS, HENRY J., M.A., M.B., B.C., M.R.C.P., 8, Portman street, W. S.
- 1893 *DONELAN, JAMES, M.B., C.M., 6, Manchester square, W. S. C.
- 1905 EVANS, A. H., M.S., M.D., F.R.C.S., 84, Harley street, W.
- 1898 FERGUSON, ARNOLD, F.R.C.S. Edin., 31, Harley street, W.
- 1905 FOX, H. CLAYTON, F.R.C.S.I., 6, Devonshire street, Portland place, W.
- O.M. *GRANT, J. DUNDAS, M.A., M.D., F.R.C.S., 18, Cavendish square, W. C. L. V.-P.
- O.M. *HALL, FRANCIS DE HAVILLAND, M.D., F.R.C.P., 47, Wimpole street, W. L. V.-P. P. C.
- 1895 HAMILTON, BRUCE, Glenbrook, 5, Crediton road, West Hampstead, N.W.
- 1905 HARMER, W. D., M.A., M.C., F.R.C.S., 45, Weymouth street, W.
- 1899 *HEATH, CHARLES J., F.R.C.S., 3, Cavendish place, W.
- O.M. *HILL, G. WILLIAM, M.D., 26, Weymouth street, W. S. C. V.-P.
- 1894 HILL-WILSON, A. E., 30, Stamford Brook road, Ravenscourt park, W.

Elected.

- O.M. HOLMES, W. GORDON, M.D., Oakley House, Oakley crescent, E.C.
- 1894 *HORNE, WALTER JOBSON, M.A., M.D., B.C., M.R.C.P., 23, Weymouth street, Portland place, W. S.
- O.M. HOVELL, T. MARK, F.R.C.S.Edin., 105, Harley street, W.
- 1895 JAKINS, PERCY S., M.D., 120, Harley street, W.
- 1894 JESSOP, EDWARD, 81, Fitzjohn's avenue, Hampstead, N.W.
- 1897 *KELSON, WILLIAM H., M.D., B.S., F.R.C.S., 17, Cavendish place, W.
- O.M. KIDD, PERCY, M.A., M.D., F.R.C.P., 60, Brook street, Grosvenor square, W. C. V.-P.
- 1895 *LACK, HARRY LAMBERT, M.D., F.R.C.S., 48, Harley street, W. S. C.
- O.M. *LAW, EDWARD, M.D., 8, Wimpole street, W. C. V.-P.
- O.M. LAWRENCE, LAURIE ASHER, F.R.C.S., 9, Upper Wimpole street. C.
- 1904 LLOYD, WM., F.R.C.S.E., 15, Harley street, W.
- O.M. MACDONALD, GREVILLE, M.D., 85, Harley street, C. V.-P.
- 1895 *MACGEAGH, T. E. FOSTER, M.D., 35, Nottingham place, W.
- 1906 MACKAY, D. M., M.D.Edin., 458A, Romford Road, Forest Gate, E.
- 1900 MACKINTOSH, J. S., Corner House, Platts lane, Hampstead.
- 1905 MCGAVIN, L. HUGH, F.R.C.S., 6, Mansfield street, W.
- 1900 NOURSE, W. J. CHICHELE, F.R.C.S.Edin., 20, Weymouth street, W.
- 1897 PAGET, STEPHEN, M.A., F.R.C.S., 70, Harley street, W. C.
- O.M. PARKER, C. A., F.R.C.S.Edin., 141, Harley street, W. S. C.
- 1893 *PEGLER, LOUIS HEMINGTON, M.D., 58, Harley street, W. C.
- 1895 PERKINS, J. J., M.A., M.B., F.R.C.P., 41, Wimpole street, W.
- 1905 PETERS, E. ARTHUR, M.A., M.D., F.R.C.S., 52, Wimpole street, W.
- 1906 PLAYFAIR, E., M.B., M.R.C.P., 57, Gloucester terrace, Hyde Park, W.
- O.M. POLLARD, BILTON, F.R.C.S., 24, Harley street, W.
- 1894 POTTER, EDWARD FURNISS, M.D., M.R.C.P., 49, Queen Anne street, W. S. C.
- 1894 *POULTER, A. REGINALD, 67, Gordon mansions, Francis street, Gordon square, W.C.

Elected.

- 1899 POWELL, H. W. FITZGERALD, M.D., F.R.C.S.Edin., 5, Harley street, W.
- 1897 RAMSAY, HERBERT MURRAY, F.R.C.S.Edin., 35A, Hertford street, Mayfair, W.
- O.M. REES, JOHN MILSOM, F.R.C.S.Edin., 18, Upper Wimpole street, W.
- 1906 ROBINSON, E. TAIT, M.D., M.Ch., R.U.I., 21, Gloucester place, Portman square, W.
- 1898 ROBINSON, H. BETHAM, M.D., M.S., F.R.C.S., 1, Upper Wimpole street, W. T.
- 1905 ROSE, FRANK ATCHERLEY, M.A., M.B., F.R.C.S., 3, Upper Wimpole street, W.
- 1894 *ROUGHTON, EDMUND WILKINSON, M.D., B.S., F.R.C.S., 38, Queen Anne street, W.
- 1893 SANTI, PHILIP ROBERT WILLIAM DE, M.B., F.R.C.S., 15, Stratford place, Cavendish square, W. S. C.
- O.M. *SEMON, Sir FELIX, K.C.V.O., M.D., F.R.C.P., 39, Wimpole street, W. P. V.-P. C.
- 1894 SHARMAN, HENRY, M.D., Sedgemoor, Arkwright road, N.W.
- 1905 SIMPSON, G. A. GARRY, 42 Cleveland Square, Hyde Park, W.
- 1893 SPENCER, WALTER GEORGE, M.S., F.R.C.S., 35, Brook street, Grosvenor square, W. C.
- 1898 SPICER, FREDERICK., M.D., 17, Wimpole street, Cavendish square, W.
- O.M. SPICER, SCANES, M.D., 28, Welbeck street, Cavendish square, W. S. C. V.-P.
- 1898 STEWARD, FRANCIS J., M.S., F.R.C.S., 125, Harley street, W.
- 1905 STEWART, G. IRVINE, M.A., M.B.Aberd., 17, Endsleigh street, W.C.
- 1905 STUART-LOW, W., F.R.C.S., 45, Welbeck street, W.
- O.M. *SYMONDS, CHARTERS JAMES, M.S., F.R.C.S., 58, Portland place, W. C. V.-P. P.
- 1894 *THOMSON, STCLAIR, M.D., F.R.C.S., F.R.C.P., 28, Queen Anne street, Cavendish square, W. S. C. L.
- 1896 *THORNE, ATWOOD, M.B., 148, Harley Street, W. C.
- 1893 TILLEY, HERBERT, M.D., B.S., F.R.C.S., 89, Harley street, W. S. C.
- 1900 TOD, HUNTER F., M.A., M.B., F.R.C.S., 111, Harley street, W.
- 1900 VINRACE, E. DENNIS, 24, Alexander square, S.W.

Elected.

- 1893 WAGGETT, ERNEST BLECHYNDEN, M.A., M.B., B.C., 45,
Upper Brook street, Grosvenor square, W. S. C.
1896 WHAIT, J. R., M.B., C.M., 124, Finchley road, Hampstead.
1897 *WINGRAVE, V. H. WYATT, M.D.Durh., 14, Stratford place,
W.

COUNTRY AND ABROAD.

*The names of Country Members who have paid a "Compounding"
Fee are printed in heavier type.*

Elected.

- 1895 BARK, JOHN, F.R.C.S.Ed., M.R.C.P.I., 54, Rodney street,
Liverpool.
1895 BARON, BARCLAY J., M.B., C.M Edin., 16, Whiteladies
road, Clifton. C.
1897 BEAN, C. E., F.R.C.S.Edin., 19, Lockyer street, Plymouth.
O.M. BENNETT, FREDERICK WILLIAM, M.D., 25, London road,
Leicester. C. V.-P.
1904 BIRKETT, H., M.D., 252, Mountain street, Montreal, Canada.
1895 BRADY, ANDREW JOHN, 3, Lyons terrace, Hyde park,
Sydney, New South Wales.
O.M. BRONNER, ADOLPH, M.D., 33, Manor row, and 8, Mount
Royd, Bradford. C. V.-P.
1894 BROWN, ALFRED, M.D., Sandycroft, Higher Broughton,
Manchester.
1902 BROWNE, J. M., M.B., B.Ch., 22, St. Patrick's hill, Cork.
1898 BURT, ALBERT H., 52, Lansdowne Place, Hove, Brighton.
1893 CHARSLEY, ROBERT STEPHEN, The Old Barn, Slough,
Bucks.
1898 CLAREMONT, CLAUDE C., M.D., B.S., 57, Elm grove, South-
sea.
1893 DAVISON, JAMES, M.D., M.R.C.P., Streate place, 16, Bath
road, Bournemouth.
1900 D'ESTERRE, J. N., 11, Devonshire place, Eastbourne.
1902 DONNELLAN, J. N., M.B., B.Ch., 4, Devonshire place,
Eastbourne.
1895 DOWNIE, J. WALKER, M.B., C.M., 4, Woodside crescent,
Glasgow. C.
1903 FARQUHARSON, JOHN MALCOLM, M.B., C.M., 2, Coates place,
Edinburgh.
1898 FOXCROFT, F. W., M.D., 47, Newhall street, Birmingham.

Elected.

- 1903 GIBB, JOHN ALDINGTON, M.B., C.M., Knightrider House, Maidstone.
- 1901 GLEGG, WILFRED, M.D., M.R.C.P.Edin., 85, Cornwall street, Birmingham.
- 1902 GREEN, A. S., M.B., B.S., 9, West Parade, Lincoln.
- 1902 HARRIS, HERBERT ELWIN, B.A., M.B., F.R.C.S., 13, Lansdowne place, Clifton.
- 1900 HAYES, GEORGE CONSTABLE, F.R.C.S., 24, Park square, Leeds.
- O.M. HODGKINSON, ALEXANDER, M.B., C.M., 18, St. John street, Manchester. *V.-P.*
- 1894 HUNT, JOHN MIDDLEMASS, M.B., C.M., 55, Rodney street, Liverpool. *C.*
- 1898 HUTCHISON, A. J., M.A., M.B., C.M., 84, Lansdowne street, Brighton.
- O.M. JOHNSTON, ROBERT MCKENZIE, M.D., F.R.C.S.Edin., 2, Drumsheugh gardens, Edinburgh. *C.*
- 1898 KELLY, A. BROWN, M.B., C.M., 26, Blythswood square, Glasgow.
- 1905 LEECH, JOSEPH WM., M.D., F.R.C.S., 12, Eldon square, Newcastle-on-Tyne. ●
- 1906 LIEVEN, A., M.D., Aix-la-Chapelle.
- 1895 LINDSAY, DAVID MOORE, 373, Main street, Salt Lake City, Utah Territory, U.S.A.
- 1906 LITHGOW, J. D., M.B., C.M.Edin., 8, Alva street, Edinburgh.
- 1904 MACDONALD, MCKAY, M.A., M.D., East Worcester street, Christchurch, New Zealand.
- 1895 MACINTYRE, JOHN, F.R.S.E., M.B., C.M., 179, Bath street, Glasgow.
- 1905 MACKENZIE, J. W., M.D., 5, Castle street, Inverness.
- 1894 MACKERN, GEORGE, M.D., Club Estrangeros, 476, B. Mitre, Buenos Ayres, Argentina.
- O.M. *MCBRIDE, PETER, M.D., F.R.C.S.Edin., 16, Chester street, Edinburgh. *V.-P. P.*
- 1898 MARSH, F., F.R.C.S., 95, Cornwall street, Birmingham.
- 1893 MILLIGAN, WILLIAM, M.D., 12, St. John street, Manchester. *C. V.-P.*
- 1905 MORITZ, SIEGMUND, M.D., M.R.C.P., 26, King street, Manchester.
- O.M. NEWMAN, DAVID, M.D., 28, Woodside place, Glasgow. *C.*
- 1900 O'KINEALY, Major, I.M.S., c/o Messrs. King & Co., Hare street, Calcutta.

Elected.

- 1905 OUSTON, T. G., F.R.C.S., 25, Eldon square, Newcastle-on-Tyne.
- O.M. PATERSON, DONALD ROSE, M.D., M.R.C.P., 15, St. Andrew's crescent, Cardiff.
- 1893 PERMEWAN, WILLIAM, M.D., F.R.C.S., 7, Rodney street, Liverpool. *C.*
- 1899 REID, ST. GEORGE CAULFIELD, Thornton Heath, Croydon.
- 1895 *RIDLEY, G. W., F.R.C.S., Ellison place, Newcastle-on-Tyne.
- 1903 RENSHAW, J. A. KNOWLES, M.A., M.D., Laurel Lodge, Washway Road, Ashton-on-Mersey.
- 1902 ROBERTS, ARTHUR, F.R.C.S.Edin., 76, London street, Reading.
- 1895 *SANDFORD, ARTHUR W., M.D., M.Ch., 13, St. Patrick's place, Cork, Ireland.
- 1904 SMURTHWAITE, HY., M.D., 8, St. Mary's place, Newcastle-on-Tyne.
- 1904 STOLTE, HERMAN, M.D., Suite 513, Goldsmith buildings, Milwaukee, Wisconsin, U.S.A.
- 1904 SYME, WM. SMITH, M.D., 10, India street, Glasgow.
- 1896 TOMSON, W. BOLTON, M.D., The Downs, Luton, Beds.
- 1896 TURNER, A. LOGAN, M.D., F.R.C.S.Edin., 27, Walker street, Edinburgh.
- 1895 VINCENT, GEORGE FOURQUEMIN, F.R.C.S.Edin., Rosezelle, Maybury road, Woking.
- 1895 *WARNER, PERCY, Rydal, Woodford Green.
- 1900 WESTMACOTT, FREDERIC H., F.R.C.S., 8, St. John street, Manchester.
- 1904 WHITEHEAD, ARTHUR L., M.B., B.S., 31, Park square, Leeds.
- 1893 WILLIAMS, PATRICK WATSON, M.D., 4, Clifton park, Clifton, Bristol. *C. V.P.*
- 1902 WOODS, ROBT. HENRY, M.B., B.Ch., F.R.C.S.I., 39, Merrion square east, Dublin.
- 1901 YONGE, E. S., M.D.Edin., 3, St. Peter's square, Manchester.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDREDTH ORDINARY MEETING, *November 3, 1905.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S. }
HENRY J. DAVIS, M.B., M.R.C.P. } Secretaries.

Present—34 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

ELECTION OF HONORARY MEMBER.

The ballot was taken for—

ERNEST PLAYFAIR, M.B.Lond., M.R.C.P., London,
who was elected a Member of the Society.

NOMINATION OF ORDINARY MEMBERS.

F. A. ROSE, M.B., B.C.Cantab. F.R.C.S., London,
B. C. GHOSH, B.A.Cantab., L.S.A., Calcutta,
T. G. OUSTON, F.R.C.S., Newcastle-on-Tyne,
were nominated for election at the next meeting.

The following cases and specimens were shown :

CASE FOR DIAGNOSIS, PROBABLY MALIGNANT DISEASE OF THE MAXILLARY
ANTRUM.

Shown by Dr. DUNDAS GRANT. The patient, a woman, aged forty-four, was referred to Dr. Grant for a swelling just below the left orbit, which appeared rather rapidly and had existed for three weeks; it was moderately firm, the skin over it was slightly thickened, the alveolar border was quite free, and no egg-shell

crackling was perceived on palpation. There was little or no pain on pressure, and there was numbness of the left half of the upper lip; there was a polypoid growth in the left middle meatus of the nose, which, when removed, was found to be somewhat papillated on the surface. The antrum was completely opaque on transillumination. Pending examination of the growth, no further exploration was carried out. In regard to the possibility of the swelling being gummatous, inquiry was made as to the family history, which was as follows: The first and second children still alive, the third still-born, the fourth died at three and a half years, there was then a miscarriage, and afterwards a boy, still living, then another miscarriage, and lastly a boy, now six years old, strong and healthy. Iodide of potassium, in 5-grain doses, was administered, and the following week it was increased to 10 grains, with the addition of $\frac{1}{2}$ drachm of the solution of perchloride of mercury. The microscopical examination made by Mr. Wingrave showed the structure to be that of a fimbriated papilloma, but with changes in the nuclei suggestive of the gamitoid arrangement found in a malignant disease. The patient had subjectively improved, but the swelling had not diminished. On puncturing the antrum from the inferior meatus by Lichtwitz's method, the trocar traversed the bone with abnormal ease and appeared to enter a large free cavity. When air was insufflated bubbles issued from the middle meatus, and a lotion driven through emerged freely, being merely blood-stained, with no admixture of pus. An exploring needle was introduced between the cheek and gum into the swelling; no blood or pus was withdrawn, and the point of the needle touched rough, bare bone. The question then arose as to whether the swelling, as at first seemed probable, was the protrusion of a malignant growth through a rapidly dehiscent maxillary bone, or, as now seemed possible, a gummatous periostitis. There was no morbid appearance in the naso-pharynx and no bulging of the floor of the antrum into the mouth or nose. The nature of the growth examined by the microscope seemed somewhat indefinite. Dr. Wyatt Wingrave had prepared sections, and with them sections of a nasal outgrowth in a case which appeared to be epithelioma of the antrum, in which a surgical friend removed the superior maxilla totally, and where recurrence has not taken place, the patient, a man, aged sixty-three, being present to-day for inspection.

The **PRESIDENT** said that from the situation, the raising of the orbital floor, and the obliteration of the orbital margin of the bone, he thought it a sarcoma and of rapid growth, and one demanding immediate operation,

The absence of nasal destruction and of depression of the palatal roof pointed to a limitation of the diseases to the orbital portion of the bone. He advised free removal by the upper and orbital portion, leaving the palate.

Dr. PEGLER proposed that these interesting sections should be referred to the Morbid Growths Committee for discussion. Dr. Wingrave, who had left the meeting, expressed a wish (to the speaker) to the same effect.

Dr. SCANES SPICER said that the diagnosis might be cleared up, by making a large opening in the anterior wall (as in the radical antral empyema operation) and examining the contents with the naked eye and histologically. He thought this should be done, and if malignant, excision of the upper jaw and affected tissues could be therefore carried out.

CASE OF A PEDUNCULATED TUMOUR, PROBABLY CYSTIC, GROWING FROM THE SUPRA-TONSILLAR FOSSA.

Shown by Dr. DUNDAS GRANT. The patient was a woman, aged sixty-eight, and the growth had probably existed for a very long time, but was only observed by the patient one month before Dr. Grant saw her, her attention having apparently been drawn to it by difficulty in swallowing owing to a temporary pharyngitis.

Dr. JOBSON HORNE considered, from his experience of similar tumours, that under the microscope the pedunculated excrescence would be found to consist mainly of tonsillar tissue with, perhaps, cystic degeneration towards the centre.

CASE OF TRAUMATIC LESION OF LARYNX.

Shown by Dr. DUNDAS GRANT. The patient was a lady, aged twenty-three, her sole complaint when brought to Dr. Grant on October 27 being loss of voice with attacks of suffocation. There were several scars across the neighbourhood of the larynx, extending upwards and backwards on the left side, the result of attempts of self-destruction by cutting the throat on May 31 last. Most of the cuts, according to the report of the surgeon who attended her at the time, were quite shallow, with the exception of one which penetrated the larynx through the thyroid cartilage. There was considerable infiltration of the left half of the larynx, and a reddish band in the form of a web ran obliquely from right to left and from behind forwards, covering a large portion of the right vocal cord and a small portion of the left. The cords did not approximate sufficiently for the production of voice, but the obstruction was not sufficient to interfere with breathing; in fact, it seemed unquestionable that the attacks of stridor were purely hysterical;

there was a slight fulness of the thyroid body. A marked feature on the exterior of the larynx was a ridge running obliquely upwards and backwards on the left half of the larynx and which seemed to be the dislocated posterior portion of the thyroid cartilage. Suggestions as to treatment, operative or otherwise, were requested, but it seemed doubtful whether anything would improve the voice except the gradual acquisition of ventricular band phonation, and there seemed no reason to interfere for the sake of inspiratory trouble.

CASE OF DIVERTICULUM OF THE ŒSOPHAGUS.

Shown by Dr. DUNDAS GRANT. The patient was a woman, aged fifty-one, exhibited on May 5; the members might remember the skiagram, showing the diverticulum full of bismuth. Dr. Grant removed the diverticulum by external operation on May 30, and for several days a tube was left in the œsophagus, passing through the nose; the patient bore it without complaint, and when it was removed she was able to swallow without difficulty. She swallowed now easier than before the operation, enjoyed her food, and had gained in weight.

IMMOBILE LEFT CORD IN A LAD AGED SEVENTEEN.

Shown by Dr. KELSON. A weakness and peculiar tone of voice had been noticed for about five years, and for the same period food and liquids regurgitated through the nose. These symptoms did not appear to follow any particular illness. On examination the left side of the palate was found to be immobile and also the left vocal cord. The knee-jerks were somewhat free, but there did not appear to be any weakness, tremor, or rigidity about the muscles of the limbs or neck.

Dr. DE HAVILLAND HALL said that he had been struck by the number of cases of immobile left vocal cord which had been brought before the Society without any definite explanation as to the cause. He was of opinion that, just as in facial paralysis, some of these cases were due to neuritis, and he mentioned a case of the kind in which complete recovery had followed the use of iodide of potassium and strychnine and the administration of electricity.

Dr. DUNDAS GRANT thought the cause of the paralysis was high up, probably in the vago-accessory nucleus, but certainly above the origin of the pharyngeal branch, as shown by the paralysis of the corresponding half of the soft palate. He detected marked nystagmus when the eyes were turned to the side; the knee-jerks were exaggerated, and the patient

stated that he had some trouble in effecting micturition, not apparently from any mechanical obstruction. He recommended complete examination of the patient from the neurological point of view, especially with regard to the possibility of the case being one of multiple sclerosis, of which, however, he would not presume to make a definite diagnosis.

Mr. BARWELL said there was distinct paresis of the left side of the palate and marked nystagmus, especially at the extremes of conjugate deviation to right and left. This pointed to a central rather than a peripheral cause; the fact that the nystagmus occurred on fixation might bear out Dr. Dundas Grant's suggestion of disseminated sclerosis.

Sir FELIX SEMON said that the combination of paralysis of the left half of the palate and of ocular nystagmus with the laryngeal paralysis definitely showed that the cause of the immobility of the left vocal cord in this case could not be due to a peripheral neuritis, but to a lesion higher up, in which the internal branch of the spinal accessory as well as the fibres coming from the nucleus ambiguus were concerned. Further than this he would not go after the one examination he had been able to make, and he certainly saw no cause for assuming that the lesion was of the nature of a multiple sclerosis. Seeing the long duration of the disease in this case, almost certainly other more characteristic symptoms would have developed if multiple sclerosis were indeed at the root of the patient's trouble. Large experience had taught him to be very reserved in committing himself to a definite diagnosis in this class of cases. Often enough these paralyses existed for many years without leading to any further development.

Dr. FITZGERALD POWELL said the case was a very interesting one. The paralysis of the cord was accompanied by paralysis of half the soft palate and nystagmus. He did not see any symptoms of disseminated sclerosis, and was of opinion that in all probability the case was a peripheral neuritis, the result of some toxin such as diphtheria or influenza. He had shown a case at a previous meeting of paralysis of one vocal cord caused by the poison of influenza.

Dr. KELSON, in reply, said that the fact that there was evidence of paralysis of the cord and palate having lasted five years was very much against it being a diphtheritic paralysis.

CASE OF ABNORMALLY LARGE EUSTACHIAN CARTILAGES PROJECTING INTO THE NASO-PHARYNX TO THE EXTENT OF INTERFERING WITH FREE NASAL BREATHING, IN A GIRL AGED SIXTEEN.

Shown by Dr. FURNISS POTTER. The patient first came under observation owing to a feeling of stuffiness in the nose. On examining the naso-pharynx, two large red swellings were seen projecting from the sides of the cavity, obstructing to a considerable extent the view of the choanæ. At the first glance they gave the impression of being enlarged posterior extremities of the inferior turbinals, but closer inspection showed that the latter could be partially seen beyond. The contour of the swellings, the orifices of the Eustachian tubes, and the well-marked Rosenmueller's fossæ justified the presumption of regarding them as

abnormally large cartilaginous extremities of the Eustachian tubes. The exhibitor was of opinion that the enlargement was not due to a pathological cause, although the patient was the subject of double chronic otorrhœa, and muco-pus could be seen adhering to the mucosæ of the naso-pharynx.

In his (Dr. Potter's) experience the condition was unique.

Dr. DONELAN said he had reason to think this condition caused obstructed breathing and other symptoms suggestive of adenoids oftener than was generally supposed. He had begun to collect cases of its occurrence, and had notes of six during the past two or three years. In the last case, about a fortnight ago, a boy, aged five, was brought to the Italian Hospital to have his adenoids removed, and on examining him under chloroform, the immensely enlarged Eustachian cartilages and pterygoid plates reduced the width of the naso-pharynx to under half an inch. It was somewhat remarkable that neither in this nor in any of the other cases were any adenoids present.

Dr. WILLIAM HILL said that his experience did not lead him to think that enlargements of the Eustachian cushion of sufficient size to cause respiratory obstruction were at all common; but he had met with one case, a youth of fifteen or sixteen, in which the cartilages were not only enormously enlarged, but were so hard to digital examination as to suggest that they might have undergone ossification. The obstruction in the naso-pharynx was so great that the patient was supposed to be suffering from adenoids. In the case of Dr. Potter, he (the speaker) had made a digital examination, and had come to the conclusion that much of the enlargement on the right side was due to great infiltration of the soft tissues of the salpingo-pharyngeal and palatal folds. The condition was analogous to that met with in pharyngitis hypertrophica lateralis; and like that condition, the present lesion appeared to be associated with the presence of irritating matter in the naso-pharynx, which possibly came from some of the posterior sinuses. He regarded the condition as inflammatory rather than due to any malformation of the Eustachian orifice.

Dr. FITZGERALD POWELL thought that a very narrow post-nasal space was a factor in intensifying the appearances of the enlarged Eustachian cushion, the pterygoid plates being inclined more towards the middle line than usual. It certainly appeared to him that the post-nasal space was contracted.

The PRESIDENT said he had been examining the post-nasal space for a good many years, and had not seen so marked a condition before. There was a good deal of mucus adherent to the pharyngeal wall and round the Eustachian orifices, which somewhat obscured the view. He suggested that after this had been attended to it would be interesting to show the case again.

Dr. PEGLER attributed the stagnation of muco-pus in the naso-pharynx to an inflammatory condition of the lymphoid tissue, which he thought contributed a good deal to the general thickening of the naso-pharyngeal structures.

Dr. FURNISS POTTER, in reply to Dr. Hill, said that he also had just examined the swellings digitally, and that they felt firm and hard, giving the impression of cartilage covered by mucous membrane. Out of the thousands of cases one saw with otorrhœa and pus in the naso-pharynx, he could not imagine that this could be the cause of such a very unusual

condition. He could not agree with Dr. Fitzgerald Powell as to the size of the post-nasal space: he thought it was of average capacity, the narrowness being only apparent owing to the projections. He also thought that these cases could hardly be quite so frequently met with as Dr. Donelan's remarks would lead one to suppose.

MAN WITH MALIGNANT DISEASE OF THE BASE OF THE TONGUE AND
EPIGLOTTIS: QUESTION OF OPERATION.

Shown by Mr. DE SANTI. The patient, aged fifty-six, had been troubled with pain and salivation for over six months, but only recently came to hospital for advice. There was a large epitheliomatous ulcer at the base of the tongue, extending to and involving extensively the epiglottis and larynx and also the pharynx. The glands on both sides of the neck were involved, and formed masses under both sterno-mastoid muscles. The patient had been losing flesh rapidly; his mother died of carcinoma. The patient was brought forward only as to the question of operation. In Mr. de Santi's opinion the disease was of so extensive a nature that he considered it could not with safety be entirely eradicated by operation. Any operation undertaken would necessitate removal of the whole tongue, the upper part of the larynx, part of the pharynx, and all the glands on both sides of the neck. Even so, and if recovery from so extensive an operation followed, it would be impossible to define the limits of the glandular involvement, and rapid recurrence was certain.

Sir FELIX SEMON said that Mr. de Santi had asked what course the surgeon was to follow in such sad cases as the one shown. This was indeed a most difficult and responsible question. He had by chance had the opportunity of seeing no less than three almost identical cases of this kind within the last three weeks, and he always felt his responsibility most keenly in advising in cases of this category. The best solution, he thought, of the difficulty, was to lay the two alternatives clearly but kindly before the patient and his friends, and leave the decision to them. Doing nothing meant, of course, a certain and very distressing death within a comparatively short time. Operation, on the other hand, meant a very serious operation, which very possibly could not be completed, and which exposed the patient to the risk of death from the operation itself, whilst no promise could be given with regard to recurrence. Still, it was the patient's *only* chance, and personally he must say that he would rather die from the operation itself than the lingering death if matters were left alone. In practice it would be found that after such an explanation patients would decide differently according to their temperaments. In the present case the chances were certainly very unfavourable, owing to the involvement of the lateral wall of the pharynx and the number of glands affected.

Dr. FURNESS POTTER said that this case had a special interest for him.

as during the last few days he had had under his observation an almost parallel case, and had only yesterday witnessed an extensive operation for the removal of the disease. This patient had the pros and cons put clearly before him almost exactly as Sir Felix Semon had just indicated, and he had decided to undergo operation. When the operator had laid clearly open to view the field of disease, he was much gratified to find that he would be able to get well outside the growth, and so insure removing the whole of it. He removed the base of the tongue with the epiglottis and part of the lateral wall of the pharynx. In Mr. de Santi's case he thought the prospects of complete removal were not so good as in the one he had just referred to, as the disease appeared to be much more extensive, involving the larynx and also the lateral walls of the pharynx to a considerable extent.

Dr. LAMBERT LACK said that these cases might sometimes be subjected to operation with a reasonable hope of success. He thought Mr. de Santi's patient might be operated on, although the disease in the throat was very extensive, and he was not prepared to say from the examination he has made, if it could all be removed. The case he had shown on a previous occasion at the Society with disease in the same region, and with extensive glandular involvement of both sides of the neck, was still alive and well, two and a half years after the operation.

Dr. SCANES SPICER referred to a case of extensive extirpation of parts for malignant disease of larynx, pharynx, and œsophagus, in which there was glandular enlargement on both sides. In conjunction with two colleagues—general surgeons—an attempt was made to extirpate the disease at one operation as described by Professor Glück. The patient's general condition did not permit of the gland removal, after the larynx, etc., had been removed, and the patient collapsed from heart failure some hours afterwards. In talking over this case later with Professor Glück, the latter said that in this case he would have removed the glands first, thus lessening the duration and shock of the main operation. This consideration might likewise apply to Mr. de Santi's case.

The PRESIDENT said he doubted if it were surgically possible to make a complete removal in this case. The larynx, with much of the pharynx and part of the tongue, would require removal, and he thought the glandular infection had got beyond the limits of complete extirpation.

Mr. DE SANTI, in reply, said he was obliged to members for their opinions. As he had already said, he did not consider the whole of the disease could be removed. He remembered Dr. Lack's case quite well, and though a brilliant result followed from operation, yet Dr. Lack's case was by no means of such an extensive nature as the case now shown. He would put the whole matter clearly before the patient and leave it to him to decide.

(Subsequently to the meeting the patient decided to have no operation done.)

WOMAN WITH PERVERTED ACTION OF THE CORDS, SHOWN AT A PREVIOUS MEETING.

Shown by Mr. DE SANTI. This woman had continued under Mr. de Santi's care as an out-patient since the June meeting. Despite all forms of ordinary treatment she had got worse, and

when seen again in September, after the holidays, was found to be suffering acutely from inspiratory dyspnoea and general cyanosis. She was accordingly admitted under Dr. de Havilland Hall, Mr. de Santi's colleague at the hospital. From Dr. Hall's observation of the patient in the hospital he concluded that there was probably more than perverted action of the cords, and some real obstruction, possibly from the enlarged isthmus of the thyroid. He asked Mr. de Santi to perform tracheotomy. After the patient had taken a few whiffs of chloroform her breathing became quite normal; a little later she became talkative, and spoke with quite a natural voice. Mr. de Santi therefore concluded the patient had no real obstruction at all, and decided not to perform tracheotomy. The isthmus of the thyroid being very enlarged, Mr. de Santi decided to excise a piece from the centre, and this was done partly to cause reduction of the enlarged lobes of the thyroid and partly for moral effect. The nurse was instructed to tell the patient on her recovery from the anæsthetic that all obstruction had been removed. The immediate result was normal breathing and speaking voice.

Dr. DE HAVILLAND HALL said that on admission into his ward the patient was cyanosed, and the breathing was so persistently of a stridulous nature that he thought there must be some direct pressure on the trachea. He was of opinion that Mr. de Santi was completely justified in the operation he had undertaken.

Dr. SCANES SPICER said that if Mr. de Santi's operation had here removed perverted action of the cords, it rather suggested the possibility of some local pressure on the laryngeal nerve supply as a cause of the puzzling perversion.

Dr. JOBSON HORNE said that in the event of a recurrence of the symptoms complained of, it would be interesting to know the effects of an administration of a general anæsthetic without the performance of an operation.

MAN, AGED EIGHTY, WITH SARCOMATOUS GROWTH OF LEFT NASAL CAVITY; QUESTION OF OPERATION.

Shown by Mr. DE SANTI. The patient had been under observation about six weeks. The left nasal cavity was filled with a soft, dark, vascular growth, polypoidal in shape, and attached, as far as could be ascertained, to the septum nasi. Pieces had been removed on three occasions, and subjected to microscopic examination by Dr. Hebb. On each occasion the report was sarcoma.

There was no opacity of the left antrum of Highmore. The question of interest was whether, bearing in mind the age and general weakness of the patient, any large outside operation was justifiable.

Dr. DUNDAS GRANT thought the growth might be completely removed with the portion of the septum on which it grew with every chance of non-recurrence. He considered the morbid histology of tumours of the septum was most peculiar, and that even when they presented features of malignancy under the microscope they were eradicable without necessary recurrence.

Dr. PEGLER remarked upon the rarity of these cases of septal sarcoma. He believed he was correct in stating that this was the first patient shown to the Society of sarcoma confined to the septum. Dr. J. W. Bond's interesting case, twice shown, last time exactly nine years ago, was attached to the septum, floor, and outer wall of the fossa. Dr. Barclay Baron showed a doubtful case of nasal sarcoma two years later. In a case of his own a great many years ago, in an old man, after removal with the snare, followed by free hæmorrhage, the growth rapidly recurred, and the patient did not live long afterwards. He was sure the Society would support him in urging Mr. de Santi to place them in possession of this specimen after the next removal for examination.

A CASE OF TUMOUR IN THE INTERARYTENOID FOLD, PROBABLY TUBERCULOUS, IN A MAN, AGED ABOUT FORTY.

Shown by Sir FELIX SEMON. The patient, a gentleman, aged forty, was sent to Sir Felix Semon by Dr. Crawford Watson, of Harrogate. Thirteen years ago he broke down with pulmonary trouble, went to South Africa, and lived there until a year ago, when he returned home. There was still harsh breathing posteriorly in the upper part of the left lung; there were a few tubercle bacilli in the sputum, but very little expectoration, and the patient was well in all other respects. Lately his voice became a little husky, and Dr. Watson discovered a swelling in the posterior part of the larynx, closely adjoining the posterior end of the right vocal cord. He wished Sir Felix Semon's opinion as to its nature, and as to the question whether the growth should be removed in view of possible tuberculous infection of the larynx from auto-inoculation from the wound thus caused.

On examination the exhibitor found a large longitudinal out-growth of moderate hardness on the right side of the interarytenoid fold closely adjoining, but not connected with, the posterior end of the right vocal cord. The tumour was covered by normal mucous membrane. In all probability the growth was of the nature of a tuberculoma, although different in aspect to the tuberculous infiltration so frequently seen in the interarytenoid fold. As the tumefaction caused very little inconvenience, and as Sir Felix shared Dr. Watson's apprehensions with regard to infection from the wound, he recommended leaving it alone for the present and being guided as to whether it should be removed at all by the

further progress of the case, but he wished to give the opportunity to the Society of seeing the rather uncommon condition of things.

Dr. DUNDAS GRANT thought this tumour was comparable to *verruca necrologica* which developed in those who made *post-mortem* examinations and which were usually slow tubercular growths; he thought the galvano-cautery might be applied, care being taken not to cauterise the adjacent portions of the interarytenoid space for fear of causing such cicatricial contraction as to prevent the arytenoid cartilages from diverging during inspiration.

Dr. DE HAVILLAND HALL said that he would not have made the diagnosis of the growth as being tuberculous in nature. He had never seen so isolated a growth in tuberculous disease of the larynx. To him it looked more like a fibroma than a tuberculoma. It was quite clear that operative interference was not advisable.

CHRONIC THICKENING AND DEFORMITY OF EPIGLOTTIS AND VOCAL CORDS OF FOUR YEARS' DURATION IN A GIRL AGED SIXTEEN; FOR DIAGNOSIS.

Shown by Dr. DONELAN.

Mr. DENNIS VINEACE remarked that, with regard to the suggestion that the patient was the subject of either hereditary or acquired syphilis, her comely appearance and general physical condition and the absence of signs were not in harmony with the victim of syphilis throughout life. If the laryngeal ulceration were due to syphilis, it was of the acquired variety.

Mr. BARWELL said that the nodular infiltration of the epiglottis, the type of patient affected—in fact, the entire aspect of the case—was typical of lupus of the larynx.

Dr. PEGLER had also come to the conclusion that this was a case of lupus, for which the best treatment would be constitutional by a course of arsenic.

Dr. WATSON WILLIAMS said that in view of the probability of this being a case of lupus, he suggested the desirability of trying the administration of tuberculin in repeated small doses, just sufficient to produce slight reaction, and continuing it for some time, as he had found gratifying results from the use of this remedy, which in his opinion might with advantage be resorted to more frequently, especially in such cases as this, where, from the deposit being none too limited, surgical procedure would be somewhat extensive before complete eradication could be anticipated.

Dr. DONELAN, in reply, said that while there were no grounds whatever to think there was any acquired syphilis, as the patient was taking a mixed antisiphilitic treatment in view of a possible congenital taint when he first saw her, he had continued that treatment for a time, especially as there was a considerable diminution in the size of the proliferations, with consequent improvement in voice. He discontinued it, however, in July, when the patient went to France. On her return lately he looked on the case as one of lupus, and commenced treatment by arsenic, but had not yet had an opportunity of pushing the dose. He would use tuberculin if the arsenic did not produce a good result.

A POINT IN THE DIFFERENTIAL DIAGNOSIS OF EXCRESCENCES IN THE
INTERARYTENOID SPACE.

Dr. JOBSON HORNE exhibited a series of photographs of macroscopic and microscopic preparations to illustrate a means of discriminating tuberculous excrescences in the interarytenoid space from those of a non-tuberculous nature. Dr. Horne said the excrescences in the interarytenoid space, with which more commonly they were concerned, were of one kind, but occasioned by different agents, and the diagnosis which they were more usually called upon to decide was whether the excrescences were of a tuberculous, simple, or syphilitic nature, and of these the most common were the tuberculous and the simple variety. Both were brought about by pachydermatous changes in the epithelium—that was to say, the epithelium underwent a hyperplasia and a metaplasia. The point to which Dr. Horne wished to draw attention was that in the simple variety (*pachydermia verrucosa simplex*) the excrescence was an exaggeration of pre-existing parts, so that the natural central furrow in the interarytenoid region was maintained in the growth, which was a symmetrical one, occupying the centre of the interarytenoid space. In the tuberculous variety (*pachydermia verrucosa tuberculosa*) the growth did not occupy a central position; it was usually developed more on one side of the space, and the central furrow was lost.

MULTIPLE PAPILLOMA OF THE LARYNX IN A MAN OF FORTY-ONE, WHICH
HAD RECURRENT AFTER THREE YEARS' TREATMENT ENDING FIFTEEN
YEARS AGO.

Dr. SCANES SPICER showed this case of ulcerating warty masses covering the whole interior of the larynx and the under-surface of the epiglottis. The nature was unequivocal fifteen years ago, simple papilloma, with no evidence of tubercle, or malignancy, or syphilis. Now, these possibilities might again demand consideration. The histological examination of parts removed this week again showed papilloma, but his study of the case was as yet not completed. He was doubtful whether, owing to the extremely diffused character of the mass and the readiness with which it bled and interfered with operative removal, the poor general state of the patient's health, and the importance of the time factor, it would not be better to perform laryngo-fissure and remove the diseased tissue. This was totally opposed to his general principle and

practice in papilloma, but if ever such a course was justified, this case appeared to be a suitable one for the procedure.

[In conversation on the case, after examining the larynx, Dr. STCLAIR THOMSON regarded it as tubercular, because the growth and ulceration had extended to the epiglottis. Sir FELIX SEMON thought it would be better to attack it through the mouth after combined chloroform and cocain anæsthesia.]

Dr. DUNDAS GRANT thought there was great suspicion of the disease being really tubercular, and that before the performance of any operation, such as thyrotomy, this diagnosis ought to be carefully considered and, if possible, excluded.

Dr. WATSON WILLIAMS said that he could not help feeling that the appearances presented were very suggestive of laryngeal tuberculosis, the more especially as there was considerable swelling and infiltration in the arytenoid regions. He thought, too, that the appearance of the patient and the fact that the pulse-rate was over 100 pointed in this direction. While, of course, all felt difficulties in diagnosis of such cases, and it was quite possible the appearances were to some extent modified by the recent local treatment, the existence of tuberculous disease should be excluded before operative measures were resorted to.

Dr. FITZGERALD POWELL thought that the first thing to be done was to make the diagnosis certain and exclude the possibility of tuberculous laryngitis by the examination of the sputum, etc. At the same time, no time should be lost in clearing the man's larynx of the growth and giving him breathing space. This could be easily done through the mouth with Mackenzie's forceps. He would strongly oppose opening the larynx. He had had considerable experience in these cases, and had found that the growths could be well kept down and eventually stopped growing by the interlaryngeal method. The removal of these growths by thyrotomy was no more efficacious in preventing their recurrence than the other method, and was more likely to injure the voice.

Dr. JOBSON HORNE said it was difficult to lay down any hard and fast rule for the treatment of papillomata in the larynx. One had to take into consideration the age of the patient and the amount of the dyspnoea. Dr. Horne cited the case of a child, aged eighteen months, in whom tracheotomy had to be performed for the relief of dyspnoea prior to the case coming under his care. The larynx was found to be packed with papillomata. In order to get rid of the tracheotomy tube there was no alternative course to performing a laryngo-fissure for the removal of the growths. This he had done, and the child was now able to breathe *per vias naturales*.

A CASE OF SUBACUTE OSTEOMYELITIS OF FRONTAL BONE, WITH EMPYEMA OF RIGHT FRONTAL SINUS, SHOWN ON MAY 5, 1905.

Dr. SCANES SPICER showed this patient again, as he had recently presented himself with a great increase of the bulging projection of bone into the orbit and also round the trephine hole over the brow. There had been considerable headache, and every two or

three days a small muco-purulent scab from the right nose. He had used mercurial inunction and potassium iodide internally up to two months ago, but since then had taken nothing. He reiterated his denial of any injury to the brow or nose, and likewise as to any specific history, of which no stigmata were to be detected. Ten grains of potassium iodide thrice daily over the last four days had, however, caused a rapid shrinking again of the bony swelling.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED-AND-FIRST ORDINARY MEETING, *December 1, 1905.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

PHILIP R. W. DE SANTI, F.R.C.S. } Secretaries.
HENRY J. DAVIS, M.B., M.R.C.P. }

SPECIAL MEETING.

A special general meeting of the Society was held prior to the ordinary meeting to consider the report of the Council *re* the union of medical societies.

The reply proposed by the Council of the Laryngological Society to the Central Committee was read by the Secretary to the meeting, and a somewhat lengthy discussion ensued.

ORDINARY MEETING.

At the termination of the special meeting the Chair was taken by Dr. WILLIAM HILL, Vice-President, in the absence of the President.

Present—27 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the following candidates, and they were elected ordinary members of the Society:

FRANK ATCHERLEY ROSE, M.B., B.C.Cantab., F.R.C.S. (London).
BENIAL CHANDRA GHOSH, B.A.Cantab., L.S.A. (Calcutta).
THOMAS GEORGE OUSTON, F.R.C.S. (Newcastle-on-Tyne).
JOHN WILLIAM MACKENZIE, M.D., C.M.Edin. (Inverness).

REPORT OF MORBID GROWTHS COMMITTEE.

Mr. Smurthwaite's specimen of (?) Malignant Disease of Larynx, June, 1905. The small fragment presented for examination showed nothing suggestive of malignant disease either of the epithelial or mesoblastic tissues.

Mr. de Santi's Case (?) Malignant Disease of Œsophagus, March,
VOL. XIII.

1905. The Committee considered that the specimen showed no evidence of the case being carcinoma or epithelioma.

Mr. de Santi's Case of Malignant Disease of the Nose, November, 1905. The specimen was one of round-celled sarcoma.

Dr. Dundas Grant's Case of Malignant Disease of the Antrum, November, 1905. The specimen was one of columnar-celled carcinoma.

The following cases, specimens, and drawings were then shown.

SPECIMEN OF A RHINOLITH.

Dr. WATSON WILLIAMS showed a specimen of a rhinolith removed from a female patient. She had had purulent discharge from the left nasal passage anteriorly for two and a half years, with cacosmia and headaches, the latter were usually central, frontal, and sometimes occipital. The discharge, smell, and the headaches entirely ceased with the removal of the rhinolith. On section, it showed a nucleus that resembled a small dirty piece of cotton-wool. The concretion was composed mainly of phosphate of calcium.

Mr. CRESSWELL BABER asked how long the rhinolith had been in the nose, and whether there was any dilatation of the nasal cavity. In a case of his own there was considerable dilatation, the septum being pushed to the opposite side, and the cheek on the affected side bulged outwards. The patient was a child, and the nucleus consisted of a plug of rag. In another similar case a boot-button formed the nucleus. It was that of a medical man. The rhinolith was removed, and the boot-button found in its centre, which the patient remembered putting into the nose when three or four years old.

Mr. DE SANTI said he had had a similar case at the hospital. A woman at forty-two came with a large, loose body in the inferior meatus of her nose, which had caused considerable ulceration and a discharge of pus. It felt very rough, irregular, and hard, and he took it to be a piece of necrosed bone, but could not find out whence it came, there being no lesion to account for a sequestrum. He tried to extract it, but it was too large, and he told the patient to come again the following week. Then, finding it could not be removed from the anterior naris, an attempt was made to push it back, and it passed into the naso-pharynx, from whence it was easily removed. She had had symptoms four years, but could not recollect having put anything into her nose. When the specimen was examined by the curator of the museum he found the nucleus to be a cherry-stone, which probably had been pushed up during childhood. Probably no inconvenience was felt until various substances became deposited on it. Headache was a prominent symptom, and there was also giddiness.

Dr. JOBSON HORNE said he had had under his care a case similar to the one described by Mr. de Santi, in which previously dead bone, the result of syphilis, had been diagnosed, and the patient had undergone a course of anti-syphilitic treatment without improvement. A rhinolith was found and removed, and the case at once cleared up. The nucleus of the rhinolith was cotton-wool. Some years previously polypi had been removed from the same nostril.

Dr. WATSON WILLIAMS, in reply, said that although there was always a nucleus, in such cases it was often only micro-organisms or natural secretion, such as in broncholiths. There was dilatation of the nasal chamber but no deviation of the septum; it was the inferior turbinal which suffered. It was interesting to hear of the association of headache in most of the cases.

CASE OF TUBERCULOUS ULCERATION OF THE NOSE, HEALED UNDER TREATMENT.

Shown by Mr. H. BARWELL. The patient, an unmarried woman, aged twenty-nine, was shown before the Society in June, 1905. There was then an ulcer of characteristic tuberculous appearance on the left anterior part of the septum, and a smaller ulcer opposite on the outer wall, as well as a soft granular patch on the left middle turbinal, which bled readily when touched. There was definite pulmonary phthisis, which had since progressed rather rapidly, and lately there had been hæmoptysis. She was treated as an in-patient at the Mount Vernon Hospital by the open-air method, and a mixture of lactic acid, formalin, and carbolic acid was rubbed in daily. In August the ulcers were completely healed, a white scar marking the site of the septal ulcer. The condition remained unchanged. A gloomy prognosis had been given when the case was first shown before the Society.

Dr. STCLAIR THOMSON asked how one was to distinguish between tubercular ulceration of the nose and lupus of the nose. The fact that the patient had phthisis did not justify calling the nasal condition tuberculous. One knew that tuberculosis and lupus had, pathologically, the same foundation; but clinically it was easier, with some experience, to distinguish between lupus and tuberculosis in the pharynx or larynx than in the nose. In 1897 he showed a case in which there was distinct lupus in the larynx, but the patient had tubercle bacilli in the lungs.¹ In 1897 Dr. Watson Williams showed a young woman with what appeared to be tuberculoma of the septum, a bluish tumour, and it was shown with drawings and specimens.² Under Dr. Watson Williams she was treated in Bristol Infirmary, and reacted violently to tuberculin. He (Dr. Thomson) saw her later in London, and showed her at the Clinical Society, after which he found he was honoured in foreign literature as showing the first case of tubercle of the nose recorded in English literature. That was a double mistake, because Dr. Watson Williams was the first to show the case, and, secondly, because it was not tubercle, for she now had typical lupus of the nose. A great deal of the septum was lost, and the disease had slowly spread over the turbinates. But the patient was in a fine condition of general health, and was now a healthy woman at twenty-eight, and married. Therefore he was inclined to agree with what had recently been said by Escat,³ namely that the only

¹ *Proceedings*, February, 1897.

² *Proceedings*, April, 1897.

³ *Annales des Maladies de l'Oreille*, vol. xxxi, No. 10, 1905

form of tubercle met with in the nose was lupus. It was generally agreed that acute tuberculosis of the pharynx—that rare but very painful disease—was unknown in the nose. The question he wished to raise was whether tuberculous ulceration in the nose, even in a phthisical patient, was not always lupus.

Dr. WATSON WILLIAMS said he had been interested to hear the upshot of his own case referred to by Dr. StClair Thomson. He thought it was an excusable mistake to call it tuberculoma instead of tuberculosis. He considered it was still an open question whether lupus was pathologically identical with tuberculosis.

Dr. JOBSON HORNE said that if the larynx was free that would be further evidence of the lesion in the nose being lupus, because lupus spread downwards and tubercle upwards, as Escat had pointed out in the paper referred to by Dr. StClair Thomson.

Mr. BARWELL, in reply, said that it was difficult to answer questions on such a thorny subject. There was no tubercular affection of the larynx. He was aware of Escat's paper, and knew that opinions differed on the subject as to whether lesions in the nose should always be called lupus, or whether tuberculosis could be distinguished. The case shown recalled to Mr. Symonds his own case, as it looked very similar. It was one of pure ulceration, rather deep, excavated, without any cicatrisation in one part, and without nodules or any large formation of granulations. That, with the rapidly advancing phthisis, made the diagnosis of tuberculosis more justifiable as distinct from that of lupus. Many regarded the prognosis of that case as bad, and now that it had healed it was not surprising to find a greater inclination to accept the diagnosis of lupus. No one in June suggested it was lupus. One could only accept the result as a criterion and call it lupus because it had healed. No bacilli were found, but scattered atypical giant cells.

CASE OF LUPUS OF THE LARYNX AND UVULA, HEALED UNDER TREATMENT.

Shown by Mr. BARWELL. The patient, a girl aged fifteen, was first seen in March, 1905; the epiglottis was thickened, the characteristic nodules extending along the right ary-epiglottic fold, with redness and ulceration of the cords; the uvula was also affected. He proposed to treat the case with frictions of lactic acid and formalin, and to excise the epiglottis if necessary. Whilst the patient was awaiting admission, the condition improved so much under arsenic that no local treatment was employed, and under good food, open air, and arsenic, the lesions had apparently healed. The nodules had mostly disappeared without ulceration, leaving the peculiar pitted appearance which had been described by McBride.

Dr. STCLAIR THOMSON said Mr. Barwell stated that the condition had healed without local treatment, though he admitted he had not seen the case recently. It was not completely healed, as apple-jelly spots were visible on one arytenoid and on the epiglottis. It showed how sceptical one ought to be before claiming results. He could show two patients

who had entirely lost their epiglottis, evidently from lupus which had completely healed. The patients were unconscious of anything the matter with themselves, and had never had treatment. If they had been under treatment it would have been easy to attribute the result to the treatment. In such cases as Mr. Barwell's, where the condition hung fire, he strongly recommended the galvano-cautery, especially in the case of people who could not afford prolonged and expensive treatment.

Dr. JOHNSON HORNE said that some years ago, whilst house-physician at St. Bartholomew's Hospital, and subsequently whilst casualty physician, he had examined the larynx in all cases presenting lupus of the face. In 9 per cent. of such cases the larynx also presented evidence of lupus. The striking point of the investigation was that symptoms referable to the larynx were so often absent when that organ was also involved.

Mr. BARWELL, in reply, said he had been very careful to say "healed *under* treatment," not "by treatment," but he thought treatment had something to do with it. The case was getting rather rapidly worse when first seen, and hoarseness was increasing, and there was a rapid improvement after commencing treatment, but he could not claim that even open-air treatment, good food, and arsenic would produce a cure in any large proportion of cases. He was not aware there was any ulceration remaining now, but he had not seen the case recently. There were one or two apple-jelly nodules on the uvula and on the arytenoid, but compared with the condition months ago, there was a remarkable improvement.

CASE OF SYPHILITIC GRANULOMATA AND STENOSIS OF THE LARYNX. THYROTOMY PERFORMED.

Shown by Mr. DE SANTI. The patient was shown by Mr. de Santi in November, 1902; the symptoms were hoarseness, slight pain, and difficulty in breathing. Both vocal cords, especially the left, were the subjects of chronic inflammation. On the left cord was a large, firm, red, sessile outgrowth; in the interarytenoid space was a large swelling, presenting cicatricial changes. The patient had been under Mr. de Santi four years previously for secondary syphilis, and amongst other manifestations had syphilitic laryngitis. He attended fairly regularly for about nine months and was then lost sight of. Subsequently he had been under Dr. Powell, who made several ineffectual attempts to remove the excrescence endolaryngeally. He had been treated with large doses of iodide.

When exhibited before the Society the case was confused with another shown by Mr. de Santi for pachydermia laryngis, and no suggestions were made as to operative treatment. Mr. de Santi at the time was of opinion that laryngo-fissure should be done and the growths and cicatricial tissue cleared away. The patient was advised to that effect, but refused operation. His breathing, some

months later, became so embarrassed that he consented to have the operation performed.

Mr. de Santi therefore performed thyrotomy, and removed the growth attached to the left cord and the cicatricial tissue in the inter-arytenoid space. The patient made an uneventful recovery, and was now brought before the Society to show the result. His voice was excellent, as also was the breathing. The growth removed from the left vocal cord was shown. It was as large as a small walnut, and consisted of exceedingly tough tissue. Mr. de Santi had come across several cases of tertiary syphilitic affections of the larynx characterised by multiple nodular out-growths, as well as the more common cases of syphilitic stenosis due to old ulceration and subsequent cicatrization, and was of opinion that in most of them laryngo-fissure should be performed. In his cases operated on the results had all been good.

SCLEROTIC HYPERPLASIA OF THE PHARYNX AND NASO-PHARYNX.

Shown by Dr. BROWN KELLY. The patient was brought to Dr. Kelly in August, 1899, on account of enlargement of the uvula. He was then thirty-four years of age. For about eight years he had been subject to slight attacks of sore throat, and for three he had experienced gradually increasing discomfort, sometimes amounting to "choking fits," due to the uvula either coming forward on the tongue or passing down behind the epiglottis. In addition, nasal respiration had been partially obstructed for a year.

On examining, the uvula was found to be greatly increased in all its dimensions, and to conceal the parts behind. The posterior wall presented a narrow tract of apparently normal tissue running down the middle, and a broad, prominent band on each side, passing upwards into the naso-pharynx, and downwards towards the larynx, and extending outwards so as to incorporate with it the corresponding posterior faucial pillar.

Examination of the naso-pharynx, which was only possible after uvulotomy, revealed a great reduction in its lumen. This was due partly to thickening of the soft palate, and partly to the continuation upwards over the posterior-superior wall of the broad bands just referred to. The thickening on the roof was least in the middle and most marked at the sides.

In the laryngeal mirror the bands on the posterior wall of the

pharynx were seen to pass downwards, and to overhang the arytenoids and posterior parts of the vocal cords.

The thickenings in all these situations were pale, smooth, and moderately firm.

The greater part of the uvula was removed and since then the patient had considered himself cured.

From the tissue removed sections were prepared, one of which was exhibited. The microscopic appearance had been described and the case reported in the 'Lancet,' April 6th, 1901. Dr. Ferguson, Professor of Pathology in the Medical School, Cairo, summarised the whole condition, from the point of view of its morbid histology, as a chronic hyperplasia of the interstitial tissue of the parts involved, of apparently progressive character, with no tendency towards degeneration, and unassociated with the presence of any specific micro-organism.

The patient's personal and family history threw no light on the origin or nature of this affection. No relation to rhinoscleroma, tertiary or hereditary syphilis, or tuberculosis could be established.

The changes that had taken place in the past six years altogether amounted to a slight increase in the roominess of the naso-pharynx and a diminution in the size of the uvula and of the right lateral pharyngeal band.

Dr. DUNDAS GRANT said it was a very interesting, but puzzling, case. It seemed to resemble some of the cases of indeterminate chronic oedema of the larynx, of which several instances had been shown before the Society. He had exhibited one such, with a gigantic infiltration of the ary-epiglottic folds, with swelling of the epiglottis, and no one seemed able to give any explanation of the condition. One could eliminate syphilis and tubercle, and when Dr. Hajek was in London he suggested it might be a form of lymphadenoma, and that arsenic would be a suitable treatment. But if his (Dr. Grant's) interpretation of the histological report in Dr. Kelly's case was correct, there seemed to be no connection with such a condition.

Dr. PEGLER said he should like to see a section which supported Dr. Brown Kelly's diagnosis of sclerosis a little more fully. The specimen on view showed rather an oedematous condition of the stroma, and no fibrous tissue. It was stained with methyl blue without a counter-stain, and apparently for micro-organisms. He agreed with Dr. Grant that the clinical appearance pointed rather to an oedematous condition of the tissues.

Dr. SMURTHWAITE said he had had a case of nasal polypi; there was in addition to the polypi what he took to be a boggy mass high up on the septum—from which it was growing—on a line with the anterior end of the middle turbinal, and having no connection with the latter. Under an anæsthetic he removed the polypi and a large piece of this mass, which was practically hard fibrous tissue. A section under the microscope

showed there was mucous membrane with marked increase of fibrous tissue. Could Dr. Kelly's case not be of a similar nature?

Dr. BROWN KELLY, in reply, said he would be pleased to accede to the suggestion of Dr. Pegler, and, if desired, refer the specimen to the Morbid Growths Committee. Sir Felix Semon recently wrote a paper on the subject, and referred to three cases observed by him, and to the case shown to-day, all of which were apparently of the same nature. Sir Felix Semon took exception, however, to the word "sclerotic" in the term applied to the affection, but he (Dr. Kelly) believed that the clinical course and histological appearances justified its use.

TWO BEAUTIFUL SKETCHES OF MULTIPLE TELANGIECTASIS OF THE SKIN
AND MUCOUS MEMBRANE OF THE NOSE AND MOUTH.

Shown by Dr. BROWN KELLY.

CASE OF CHRONIC PHARYNGITIS WITH POLYPI OF UVULA.

Shown by Dr. PETERS. A. H—, aged seventeen, cashier, had suffered with chronic pharyngitis and rhinitis for three years. During this time she noticed that her uvula was much elongated. Occasionally during deglutition it troubled her; otherwise its presence was not noticeable. The uvula was in all $1\frac{3}{4}$ inch in length, and somewhat œdematous. The proximal inch contained muscular tissue, and the last $\frac{3}{4}$ inch terminated in a papillomatous-looking mass $\frac{1}{4}$ inch in diameter. There was also a smaller similar excrescence $\frac{1}{2}$ inch in length at the junction of the uvula with the soft palate. Usually the main appendage clung to the right anterior pillar and lay curled in the right glosso-epiglottic pouch.

Dr. DUNDAS GRANT remarked on the absence of inconvenience from such a gigantic uvula. A similar case had been previously shown, and he had seen one or two in his own practice, with a long uvula, which seemed to tail down into the glosso-epiglottic vallecula, and almost into the hyoid fossa, but producing no discomfort. Doubtless the parts became habituated to the perpetual contact. If Dr. Peters were to remove a small portion, it would be interesting to know whether the patient felt such disturbance as often accompanied the more moderate degrees of elongation of the uvula.

Dr. H. J. DAVIS said that some years ago he showed a case of an old man¹ where the uvula was so long that it practically hung like a pigtail into the glottis. As there was no discomfort from it—and the patient very infirm—he left it alone. He had observed that if the uvula was very long and pendulous there was often not much discomfort, but should it happen to be only a little longer than usual there was often a great deal. In such cases there was often trouble in the nose in the form of nasal obstruction, and if that were attended to the uvula would sometimes shorten of itself. He looked upon it as an indication of nasal obstruction. The present case with the polypi was very unusual.

¹ *Proceedings*, March, 1901.

Dr. PEGLER described a peculiar abnormality of the uvula which he had recently seen in his clinic. The body of the uvula was rather long to begin with, but was joined by a thread-like connection a quarter of an inch long to an oblong body about the same length. In spite of the curious excursions of this growth with every movement of the soft palate the patient was unconscious of its existence and had no symptoms attributable to it.

Dr. WESTMACOTT said if removal was decided upon it might be well to deal with the tonsils also.

Dr. PETERS, in reply, said he used the term polypus because he thought it consisted principally of fibrous tissue. He proposed to remove it and cut sections.

CASE OF SWELLING OVER THE LEFT SUPERIOR MAXILLA IN A MIDDLE-AGED WOMAN (formerly shown).

Shown by Dr. DUNDAS GRANT. Since the last meeting the patient had continued to take anti-specific remedies with regularity. There was free discharge from the nose, but the swelling over the superior maxilla had diminished considerably, and the patient subjectively much relieved; although the numbness of the lip had not entirely disappeared, it was less than formerly. There was decidedly less infiltration of the skin over the swelling, and, under the circumstances, the exhibitor thought that the Society would consider him justified in still delaying operation.

Mr. DE SANTI said the experience mentioned by Dr. Grant was not uncommon. The pathologist not infrequently reported that the condition was malignant, yet the disease cleared up under iodide of potassium. Or he would say it was syphilitic and it turned out to be malignant. Some time ago a man under Mr. de Santi's care had a growth of the external auditory meatus, which was clinically a typical epithelioma. He excised a large piece and sent it for examination, and received the laconic answer, "epithelioma." The man had secondary syphilis at the time. The condition had come on much more rapidly than malignant ulceration would, and there was an absence of enlarged glands. A week after the administration of mercury and iodide of potassium the patient returned with the growth half its former size. If he had not been in the hospital it would have been regarded as cancer. The growth was a huge condyloma. In March he showed a woman with epithelioma of the larynx and pharynx, which had been pronounced simple; but the woman was now dying of carcinoma.

Dr. PEGLER said that the Morbid Growths Committee had very carefully considered the specimens submitted to them, and both of them, especially Mr. de Santi's case, presented considerable difficulty. In the latter case they could only speak from the specimens of tissue under consideration, which they ultimately concluded were not carcinomatous, whatever might be the clinical behaviour of the growth. Dr. Grant's case was a fairly typical papillomatous spheroidal cell carcinoma, of which other specimens, malignant in character, were in the cabinet.

Mr. WAGGETT said that the specimen was similar to others he had seen which ran a malignant course.

Dr. WESTMACOTT said he had three similar cases, in which the clinical and pathological diagnoses were at variance. One was constantly encountering the same difficulty with regard to morbid growths, even where examinations were made by skilled pathologists at more than one centre. There should be a more definite scheme, either for getting a more suitable piece of tissue for examination or for having a more definite form report.

Dr. DUNDAS GRANT, in reply, said he felt justified in watching the case a little longer; possibly it might even yet confirm the report of the pathologist. It would be a great matter if the sections which had been before the Society for some time as doubtful cases could be brought up and reconsidered in the light of their subsequent histories, if these could be obtained, so that the morbid anatomy of those parts could be better established. The pathologist realised that there were microscopical as well as clinical difficulties in diagnosis. Dr. Grant asked whether the Committee thought the microscopical appearances in this case so absolutely typical as to exclude all doubt.

A CASE OF TERTIARY SYPHILIS OF THE LARYNX.

Shown by Dr. G. C. CATHCART.

Mr. DE SANTI said he had had a few such cases at different times, on all of which he operated because of their trouble in breathing, by laryngo-fissure. The present patient would be well advised to have her thyroid split, the growths removed, and the parts trimmed up, especially using Waggett's thyrotomy cutting forceps. The ultimate result would be most excellent.

RECENT NASAL POLYPUS AND SINUSITIS IN A PATIENT WITH LONG STANDING ATROPHIC RHINITIS.

Shown by Dr. WILLIAM HILL (in the chair).

Dr. WATSON WILLIAMS said the two conditions became associated but were not interdependent. It was difficult to know what to do. He had a case of atrophic rhinitis in whom he had opened both antra and washed them out for a long period. But the patient went to someone else, who did a double radical antral operation. This patient was good enough to return and show himself as cured.

Mr. WAGGETT did not think the case to be one of atrophic rhinitis.

Mr. STUART LOW said that he had recently had a similar case in private, the patient being a lady aged fifty years. She complained of excruciating pain in the area supplied by the infra-orbital nerve and the ramus subcutaneus malæ. Polypi were found in the opposite nostril. Antral transillumination on the painful side showed only partial dimness. There was no pain on pressure on the antral wall, but on pressing the finger upon the floor of the orbit downwards considerable pain was elicited. He was undecided whether to perform evulsion of the infra-orbital nerve or a radical antral operation. He, however, preferred first to explore the maxillary antrum, and found it packed with soft mucous polypi. There had been no recurrence of the severe pain, and the cure was complete. There were no crusts in the nostrils, but only a condition of rhinitis sicca. He could not find any crusts in Dr. Hill's case.

REPORT ON THE FATAL TERMINATION OF THE CASE OF INCRUSTATIONS IN THE TRACHEA, WITH AT TIMES WELL-MARKED STENOSIS; SHOWN BY DR. EDWARD LAW AT THE MEETINGS OF THE SOCIETY ON NOVEMBER 4 AND DECEMBER 2, 1904, AND MARCH 17, 1905, AND DULY REPORTED IN THE "TRANSACTIONS."

Dr. Edward Law saw the patient on May 30 after a visit to the seaside of seven weeks' duration. The general health was good, but the difficulty in breathing continued and varied in intensity. The crusts in the trachea were less marked than usual. The patient returned home, and the following communication was written by her aunt:

"After seeing Dr. Law on Tuesday, May 30, the patient remained in her usual health until Saturday morning, June 3, when she had breakfast about eight o'clock. She laughed and talked to her sister for some time and then went to a boxroom and knelt down to look in her trunk, asking a little girl who was with her to go away. The patient immediately followed the child and put her arms on her aunt's shoulders, looking at her as if she wished to say she was choking. The mouth was wide open, but she was quite unable to speak, and instantly became discoloured. The eyes rolled, the teeth were set, and the throat was hard and rigid. She neither struggled nor made a sound, and was dead before her uncle could reach her, although he was only at the bottom of two small flights of stairs."

The aunt considers that under no circumstances could anything have been done, as it all happened so very suddenly, the time from speaking to her little girl until the patient was dead being scarcely two minutes.

Dr. Law asked the members not to confuse this case with the one of excrescences, incrustations, or chalky deposits low down in the trachea shown by himself at the meeting of the Society on May 2, 1902, and at the annual meeting of the British Medical Association in Manchester on July 30, 1902.

REPORT BY DR. G. C. CATHCART.

"A *post-mortem* examination was made three days after death. The whole corpse was swollen, owing to *post-mortem* decomposition, the features being unrecognisable and the neck obscured behind the swollen chin and breast, which met in front of it. Blood and mucus were exuding from the mouth and nostrils; the general aspect

resembled that of a death from drowning. The larynx and trachea were removed *en masse* through the usual median incision, and preserved in 5 per cent. solution of formalin. No other organs were examined, permission for a partial autopsy only having been obtained."

REPORT BY DR. JOBSON HORNE.

"For the opportunity afforded to us of seeing the larynx and trachea, we are indebted to Dr. G. C. Cathcart who performed the autopsy.

"The larynx with the trachea was removed seventy-eight hours after death. It was found to be occupied with a membranous material which was present in sufficient quantity to account for death. Owing to the advanced *post-mortem* changes it was impossible to conduct usefully any bacterioscopic or histological investigation with a view of ascertaining the nature of this material. The specimen had to be placed immediately in a strong solution of formalin. When hardened it was opened in the usual way, and presented to the naked eye no morbid appearances apart from those due to *post-mortem* changes."

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

FOURTEENTH ANNUAL GENERAL MEETING, *January 12, 1906.*

CHARTERS J. SYMONDS, President, in the Chair.

Present—22 members.

The minutes of the last Annual General Meeting and of a Special General Meeting, held on December 1, 1905, were read and confirmed.

Dr. Middlemass Hunt and Dr. H. Smurthwaite were appointed scrutineers of the ballot, and the following officers were elected for the year:

President.—Charters J. Symonds, F.R.C.S.

Vice-Presidents.—F. Willcocks, M.D., J. B. Ball, M.D., William Hill, M.D., P. Watson Williams, M.D.

Hon. Treasurer.—H. B. Robinson, F.R.C.S.

Hon. Librarian.—StClair Thomson, M.D.

Hon. Secretaries.—H. J. Davis, M.B., W. Jobson Horne, M.D.

Council.—Felix Semon, K.C.V.O., M.D., Philip de Santi, F.R.C.S., J. Middlemass Hunt, M.B., S. Paget, F.R.C.S., Atwood Thorne, M.D.

The following Reports were read and unanimously adopted:

REPORT OF THE COUNCIL FOR THE YEAR ENDING JANUARY 12, 1906.

The meetings held in 1905 have been of the usual number and have been attended by an average of thirty-two members.

The number and quality of the cases and specimens shown has been well up to the level of former years.

The session 1905 will ever be memorable in the annals of the Laryngological Society of London by virtue of the celebration by the Society of the Centenary of Señor Manuel Garcia, and of the Jubilee of the discovery of the laryngoscope by the famous maestro. The ceremony took place on March 17, 1905, the date of the distinguished honorary member's one hundredth birthday. In the morning addresses were presented by numerous musical and learned societies. A special meeting of the

Laryngological Society was held in the afternoon, graced by the presence of a large number of distinguished foreign laryngologists. The banquet in the evening was attended by over 400 guests.

A Special General Meeting of the Society was held on Friday, December 1, 1905, to consider the Report of the Council *re* the Union of Medical Societies, and after considerable discussion a suitable Report was drawn up and passed.

During the past session the size and printing of the *Proceedings* have been altered in accordance with an arrangement entered into with the JOURNAL OF LARYNGOLOGY. The arrangement has worked well, and has fulfilled its object—namely, an economy to the Society in printing expenses.

There have been two resignations and one death, and eight new members have been elected during the year 1905.

THE HONORARY TREASURER'S REPORT.

The finances of the Society are in a sound state. The reduction of the balance from £27 14s. 1d. to £1 14s. has been caused by the payment of several outstanding accounts for 1904, and by an increased rental. All the accounts for the year 1905, I am pleased to say, are paid.

BALANCE SHEET, 1905.

INCOME.			EXPENDITURE.		
	£	s. d.		£	s. d.
Balance January, 1905 . . .	27	14 1	Rent	52	10 0
Subscriptions	138	10 11	Stamp for New Lease	0	5 0
Entrance Fees	8	8 0	Reporting	21	13 10
Sale of <i>Proceedings</i> , etc.	5	14 4	Preparing Index	2	12 0
Interest on Deposit	2	5 9	Annual Dinner	4	4 0
			Pathological Committee	0	9 0
			Baker—Microscopes	4	19 2
			Adlard—Printing	68	8 1
			Pulman	0	3 6
			Hodgkinson	0	7 7
			Martindale	0	3 8
			Wallas	0	3 0
			Mathew (porter)	2	0 0
			Garcia Testimonial—		
			Curator	1	16 8
			Wyon	7	7 0
			Berlin Photo. Society	5	5 0
			Watson	0	12 0
			Bank Charges	0	19 2
			Secretaries' Expenses	5	18 4
			Treasurer's „	1	2 1
			Balance	1	14 0
	£182	13 1		£182	13 1

Deposit at Bankers (London Joint Stock Bank) £150.

Examined and found correct,

ATWOOD THORNE, }
E. H. PETERS, } *Auditors.*

January 11, 1906.

HY. BETHAM ROBINSON, *Hon. Treasurer.*

THE HONORARY LIBRARIAN'S REPORT.

The Library and all arrangements connected with it continue to be very satisfactory. These arrangements, and the list of our Exchanges, are the same as detailed in the Report of January, 1905.

By curtailing the number on our Free List we have been able to effect considerable economy, and by the sale of back numbers and cases for binding the Society has added £5 14s. 4d. to the credit side of the Treasurer's Report.

Our thanks are due to Sir Felix Semon for presenting the bound volume of the *Centralblatt für Laryngologie* for the year 1905, and to the editors for a similar gift of the JOURNAL OF LARYNGOLOGY.

Dr. Birkett, of Montreal, has presented the volume edited by Dr. Jonathan Wright on "Diseases of the Throat, Nose, and Ear." Other contributions are appended to this Report by the Assistant Librarian of the Royal Medical and Chirurgical Society, Mr. Archibald Clarke, who has kindly seen to the cataloguing and distributing of our books.

LIST OF DONATIONS.

Presented by the Author.

1. Malignant Disease of the Larynx (Carcinoma and Sarcoma). By Philip R. W. de Santi. London, 1904.
2. Laryngeal Phthisis, or Tubercular Laryngitis. By Richard Lake. Second edition. London, 1905.
3. Un cas d'hémiplégie droite du larynx et de la langue avec paralysie du sterno-cléido-mastoïdien et du trapèze du même côté, suivie d'hémiplégie totale passagère du côté gauche du corps. (Extr. de la Presse Oto-laryngologique belge, No. 2, 1905.) Par A. G. Tapia. Bruxelles, 1905.
4. Een door operatie genezen otogeen hersenabsces. (Overgedrukt uit het Nederl. Tijdschrift v. Geneeskunst, Jrg. 1904, Dl. ii, No. 23.) H. Burger.
5. Disturbi psichici ed otopatie. (Estratto della Gazzetta degli Ospedali e delle Cliniche, N. 40, Anno 1905.) Per Vittorio Grazi. Milano, 1905.

Presented by the Society.

6. Jahresbericht der Ungarischen Rhino-laryngologischen Gesellschaft, Band i, 1904. Redigirt von Hugo Zwillinger. Budapest, 1905.
7. Nederlandsche Keel-Neus en Oorheelkundige Vereeniging. Twaalfde Jaarvergadering, op 23 en 24 April, 1904, in het Clinicum van Prof. Pel. te Amsterdam. (Overgedrukt uit het Nederl. Tijdschrift v. Geneeskunde, 1904, Dl. ii, No. 5.)
8. Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde. xii, Jahresversammlung, am 23 und 24 April, 1904, in Amsterdam. (Separat-abdruck aus der Monatschr. f. Ohrenheilkunde, 1904, No. 11.)
9. Sitzungsberichte der Wiener Laryngologischen Gesellschaft, 1904. (Separat-abdruck aus der Wiener Klinischen Wochenschrift, 1904, No. 10.) Wien und Leipzig, 1905.

Presented by the Association.

10. Transactions of the Twenty-Seventh Annual Meeting of the American Laryngological Association, held at Atlantic City, N.J., June 1, 2, and 3, 1905. New York, 1905.

Presented by the Society.

11. Proceedings of the Brighton and Sussex Medico-Chirurgical Society for the Session 1904-5, and the 58th Annual Report. Brighton, 1905.

Presented by Dr. H. Birkett, of Montreal, Canada.

12. A Treatise on Diseases of the Nose, Throat, and Ear, for Students and Practitioners. By various authors. Edited by Jonathan Wright. Vol. ii. Philadelphia and New York.

Presented by the Author.

13. Des végétations adénoïdes chez les nourrissons. (Extr. du Jour. de Méd. de Bordeaux, 1905.) Par E. J. Moure. Bordeaux et Paris, 1905.
14. Contribution à l'étude de la Commotion Labyrinthique par la fondre. Par V. Grazi.
15. In Memoriam—Professor A. A. G. Guye. By H. Burger.

Presented by the Society.

16. Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde. xiii, Versammlung als Subsection des X. Niederländischen Natur- und Medicinischen Congresses in Arnheim, 28 April, 1905. (Aus der Monatschr. f. Ohrenheilkunde, 1905, No. 8).

Presented by the Author.

17. De Keel- Neus- Oorheelkunde als Studievat voor den Aanstaanden Arts. By H. Burger.

Presented by H. Burger.

18. Nederlandsche Keel-, Neus-, en Oorheelkundige Vereeniging. Dertiende (Buitengewone) Vergadering, als Subsectie van het Tiende Nederlandsch Natuur- en Geneeskundig Congres te Arnhem, 28 April, 1905..

REPORT OF THE CURATOR OF THE PATHOLOGICAL COLLECTION.

As hitherto, the members have most generously contributed specimens of their exhibits and private collections to the Society's cabinet. To all these gentlemen, in the name of the Society, I wish to accord my indebtedness, and to assure them of the pleasure it will always give me to display the microscopical preparations in this valuable collection whenever they give me the opportunity.

The following is the list:

A. CATALOGUE REFERRING TO *Proceedings*.

I. *Nose and Accessory Cavities.*

1. Epithelioma of Nose and Accessory Cavities, December, 1904, vol. xii, p. 18, Dr. Lambert Lack.
2. Bony Tumour of Nasal Cavity (Left Side), December, 1904, vol. xii, p. 17, Dr. Lambert Lack.
3. Squamous Cell Carcinoma of the Nose, March, 1905, vol. xii, p. 75, Dr. Atwood Thorne.
4. Columnar Cell Carcinoma of Antrum, November, 1905, vol. xiii, p. 1, Dr. Dundas Grant.
5. Round-Cell Sarcoma of Nasal Septum, November, 1905, vol. xiii, p. 9, Mr. P. de Santi.

II. *Mouth and Tongue.*

6. Fibroma of the Tongue, June, 1905, vol. xii, p. 127, Dr. W. H. Kelson.
7. Angioma of the Palate, June, 1905, vol. xii, p. 132, Dr. Lambert Lack.

III. *Pharynx.*

8. Tuberculous Ulceration of the Pharynx, January, 1905, vol. xii, p. 43, Dr. F. H. Westmacott.

IV. *Larynx.*

9. Sarcoma of the Interior of the Larynx and Thyroid, April, 1900, vol. vii, p. 86, Dr. Dundas Grant.
10. Epithelioma of the Right Vocal Cord, January, 1905, vol. xii, p. 41, Sir Felix Semon.
11. Squamous Cell Epithelioma of Larynx, February, 1905, vol. xii, p. 56, Mr. P. de Santi.
12. Soft Fibroma of Larynx and Neck, March, 1905, vol. xii, p. 71, Sir Felix Semon.
13. Tubercle of Larynx (Arytenoid Region), March 17, 1905, vol. xii, p. 84, Mr. Harold Barwell.
14. Pachydermia of Vocal Cord, June, 1905, vol. xii, p. 129, Mr. H. Smurthwaite.
15. Squamous Papilloma of Left Vocal Cord, June, 1905, vol. xii, p. 135, Dr. Scanes Spicer.

B. SUPPLEMENTARY CATALOGUE.

I. *Nose and Accessory Cavities.*

1. Bleeding Polypus of the Septum (Granuloma type), Dr. Herbert Tilley.
2. Bleeding Polypus of the Septum (Fibro-angioma type), Dr. Wyatt Wingrave.
3. Bleeding Polypus of the Septum (Soft Cell Fibro-angioma type), Dr. Wyatt Wingrave.
4. Bleeding Polypus of the Septum (Fibro-angioma type), Mr. H. Betham Robinson.
5. Polypoid Mucous Hypertrophy of the Septum, Dr. W. H. Kelson.
6. Lupus of the Inferior Turbinal, Dr. W. H. Kelson.
7. Fibro-Angioma of the Naso-Pharynx, Dr. Dundas Grant.

II. *Mouth and Tongue.*

1. Granulomatous Ulcer of the Tongue (two slides), Dr. L. H. Pegler.

Alteration of Rule XIX : "The Annual Meeting shall be held in the month of January, and shall be followed by a Dinner of the members and their friends."

It was unanimously agreed that this rule be altered to "in the month of June" instead of January.

The meeting then adjourned.

ONE HUNDRED AND SECOND ORDINARY MEETING, *January 12, 1906*

CHARTERS J. SYMONDS, President, in the Chair.

HENRY J. DAVIS, M.B., } Secretaries.
W. JOBSON HORNE, M.D., }

Present—22 members and 2 visitors.

The minutes of the last ordinary meeting were read and confirmed.

The following gentlemen were nominated for election as ordinary members :

Arthur Evans, M.S., M.D.Lond., F.R.C.S.Eng. (London)?
W. Irvine Stewart, M.B.Aberd.
A. Lieven, M.D. (Aix-la-Chapelle).

The following communications were made :

A CASE OF SINUS OF THE CHIN.

Dr. W. H. KELSON showed a woman, aged twenty-five, with a sinus situated in the centre of the tip of the chin; the patient had noticed it about four years, and from time to time it discharged a honey-like fluid. A probe passed upwards and backwards about half an inch; no bare bone could be felt. The question was whether it was due to want of closure of the mandibular fissure or to some other cause, such as diseased bone.

Mr. BETHAM ROBINSON said that, considering the fact that the duration was not more than four years, and the local conditions, he regarded it as inflammatory, and that it was probably connected with a sinus which tracked up to the root of one of the incisor teeth.

The PRESIDENT said such cases were not uncommon in the general Out-Patient room, and he had seen a fair number of them. Scraping-out had been tried, but it had invariably been necessary to sacrifice the incisor tooth. It would be found that the fang was exposed at the bottom of the sinus. The trouble was probably caused by the right central incisor. It did not give rise to any pain.

A CASE IN WHICH A TRACHEAL CANNULA HAD BEEN WORN FOR NEARLY TWENTY-SEVEN YEARS ON ACCOUNT OF INCOMPLETE BILATERAL PARALYSIS OF THE POSTERIOR CRICO-ARYTENOID MUSCLES, WHICH HAD REMAINED UNCHANGED ALL THAT TIME.

Shown by Sir FELIX SEMON. This patient, now aged seventy-four, was shown on April 25, 1879, to the Clinical Society, and his case is briefly referred to in the twelfth volume of its 'Transactions,' 1880, as well as in my paper "On Mechanical Impairments of the Functions of the Crico-Arytenoid Articulation," *Medical Times and Gazette*, 1880. It is the third case of my own referred to in the collection.

When I showed the case before the Clinical Society, the anterior two thirds of the vocal cords remained almost closed on inspiration. The posterior ends suddenly diverged at a remarkably large angle, and left a considerable triangular opening between their borders and the interarytenoid fold. The dyspnœa, however, was considerable enough to necessitate tracheotomy, which I performed in 1879. The cause of the abductor paralysis was perfectly obscure, and has remained so ever since. Later on a slight change took place in the laryngeal appearance. Absolute immobility of the right arytenoid cartilage, with considerable

tumefaction and change of position, supervened, and pointed to ankylosis of the crico-arytenoid articulation having been added to the pre-existent abductor paralysis. With that one exception the condition has remained *in statu quo* all these twenty-seven years, and the case is now shown again as an historical curiosity, illustrating on the one hand that a permanent wearing of a tracheal cannula does not necessarily interfere with the duration and amenities of life, and, on the other, that such grave changes in the larynx as those described may continue for a period so unusually long without undergoing any change and without their cause becoming apparent.

Mr. HERBERT TILLEY said he had already asked Sir Felix Semon whether œdema over the arytenoid cartilages was present before he inserted the tracheotomy tube. Some eight years ago there was a patient in the Great Portland Street Throat Hospital who came with marked dyspnœa, which had to be relieved immediately. He put in a tracheotomy tube, without a general anæsthetic, because the dyspnœa was extreme. A few days afterwards, when the patient was comfortable, it was impossible to see the larynx; there was marked swelling of the mucosa over the arytenoids, and they presented the appearance frequently seen in tubercular disease of that region. He (the speaker) had kept the man under his notice ever since, and he was in excellent health; indeed he was quite stout. There had never been any further trouble since the insertion of the tube. He had often wondered whether it was due to paralysis of the cords, or whether it was a case of rheumatic inflammation of both crico-arytenoid joints. Sir Felix Semon's case was one of much longer standing than his own, but, judging from the history and present appearance, it appeared to be of an almost identical nature. He mentioned it because there were similar but more recent cases going about. Two years ago he saw a medical man who came in a great hurry because of very difficult breathing. Examination of the larynx showed marked œdema over the left arytenoid. For other reasons he gave large doses of salicylate of soda and the usual general treatment for acute rheumatism. A few days afterwards the patient had rheumatism in the left shoulder-joint, and later in other joints of the body, confirming him in the belief that sometimes one met with acute rheumatic inflammation of the crico-arytenoid joints.

Dr. PETERS said he had a case of double abductor paralysis in a woman who had worn a tracheotomy tube for three years. She experienced attacks of œdema of the arytenoids from time to time since, and previous to the tracheotomy, but he thought she was now developing signs of tabes.

CASE OF ULCERATION OF THE PHARYNX (PROBABLY SPECIFIC) PRESENTING UNUSUAL FEATURES.

Shown by Dr. DUNDAS GRANT. The patient was a man, aged twenty-eight, with destructive ulceration of the pillars of the fauces

and both sides of the pharynx, quite superficial though on an area of infiltration on the right side, but extending deeply and presenting very typically the appearance of the breaking down of gummatous infiltration on the left. The exceptional feature in the case was the unusually early date at which the destructive lesions appeared, the initial infection having occurred about eight months previously, when there was no visible primary ulcer, but what appeared to be an ordinary urethritis. There were no secondary appearances on the skin, and the first suggestion that the infection was specific was the occurrence, about seven weeks later, of a sore throat with all the characters of an ordinary-looking tonsillitis, which subsided, leaving behind it a superficial patch on the right anterior faucial pillar, which, however, was not a typical mucous patch. I then had the opportunity of seeing him (August 1, 1905), and in view of the probability of it being syphilitic, recommended that he should be treated accordingly. He improved very considerably until the month of November, when his throat was reported to be ulcerating. He had been taking mercury continuously by mouth, and was then put upon inunctions and moderate doses of iodide of potassium. In spite of this the ulceration persisted, and was accompanied by such pain that the patient was unable to take sufficient food. He got continuously thinner, developed evening temperatures, and such pulmonary symptoms that his medical adviser suspected tuberculosis, there being dulness on percussion at the right apex, whispered pectoriloquy, and moist sounds; the opsonic index was taken and found to be normal; the throat then presented its present appearance, and it was difficult to exclude the possibility of a tuberculous factor in the case, more especially as the patient had been thrown much in contact with a phthisical employer. A portion of the tissue was removed and examined under the microscope, and its structure found to be characteristic of gumma and not of tubercle. There were no bacilli, but abundant staphylococci.

Sir FELIX SEMON said it was curious that Dr. Grant should have brought the case forward on the day when a lecture of his (Sir Felix's) on the same subject was published in the *British Medical Journal*. In that lecture he dealt with the question which Dr. Grant put before the Society—namely whether gummatous phenomena ever developed so shortly after primary infection. He claimed that the subdivision into secondary and tertiary was purely conventional, and that frequently enough they intermingled. In rarer cases tertiary symptoms developed in the first year after infection; he had himself seen two such cases. In Dr. Grant's case the appearance was so typical of gumma on the posterior

wall of the pharynx that he had jocularly made the observation in the other room that if he were examining on this case and the candidate could not say what the condition was, he would not consider it safe to let such a student loose upon the public. What seemed a serious feature of the case was the possibility of an erosion of the vertebral artery, and one should be on the look-out for such a contingency.

Dr. McBRIDE said the case of Dr. Grant and the remarks of Sir Felix Semon reminded him of an interesting example of the rapid destructive ulceration which might follow a primary syphilitic sore. It was one in which the affection occurred either in late spring or early summer, and he was called to see the patient in July, at the patient's own house, in consequence of which he had no notes. By the time he saw the patient he had lost practically the whole palate. The course had certainly not been longer than two or three months. Therapeutically the case was interesting, because his medical man, quite naturally, had been treating him with mercury. When Dr. McBride saw him he suggested the discontinuance of the mercury and the substitution of iodide of potassium. The ulceration then at once ceased.

Dr. LIEVEN (Aix-la-Chapelle) said he thought the ordinary ways of administering mercury would not do in cases like Dr. Grant's. He would use injections of calomel, which seemed to be a specific for such cases. The term "precocious syphilis" seemed to be applicable to such cases, and they gave rise to great trouble in treatment. Injections ought to be intra-muscular, and should be continued for five or six weeks. For the subsequent treatment inunction could be employed. Calomel injections produced a very rapid effect, and benefit would be revealed in a fortnight's time. Occasionally there were cases in which even that preparation of mercury did not produce any good effect, but caused a reaction in the specific tissue; and that point was brought out by Sir Felix Semon in his lecture. In the cases mentioned by Sir Felix there was produced by iodide an effect which he (Dr. Lieven) spoke of before the German Laryngological Society as a tubercular-like effect; it was followed by a sudden breaking-down of the tissue, with fever. In the first two cases which he saw, independently of Sir Felix's, the nose was affected, and on the day following the treatment there was swelling of that organ. Those cases, as well as Sir Felix Semon's recent ones, were cured by sarsaparilla, known as the Zittmann method. Perhaps that would be tried in the present case if other measures failed.

The PRESIDENT agreed with Sir Felix Semon's remarks, that the old division of the manifestations of syphilis into periods was purely artificial, and that severe ulcerations were sometimes seen in very early stages of the disease. He had been much interested in the remarks concerning treatment, and had found that the dusting on of calomel, or its inhalation, putting three or four grains on a spoon, holding it over a candle, getting the patient to take a mouthful, and blowing it through the nose, did immense good. He had found such cases did better in bed. The sarsaparilla produced much sweating, and that certainly seemed to make other remedies more effective. Sarsaparilla was a very old remedy for syphilis. There was a small dose of iodide in the sarsaparilla as used in Zittmann's method.

Dr. LIEVEN, in further comment, said many doubts had been raised, especially in England, as to the value of sarsaparilla treatment; but he believed that recent observations led to the idea that sarsaparilla had a specific action in syphilis, because it appeared to act in a similiar manner to mercury. If the active substance of it, glycosates, were given in large

quantities, it would be likely to cause salivation and enteritis, the former appearing to closely resemble that produced by mercury. He had seen that occur when the patient, in his anxiety to get well, took more than the proper doses.

Dr. GRANT, in reply, said the question in his mind was as to whether there was anything beyond syphilis in the case which led to it taking on a malignant phase at an early period. All had seen the rupial ulceration which sometimes occurred in syphilis, with destructive effects on the ala of the nose, and it had been advised that the specific remedies should be stopped and the patient sent to the seaside. To the suggestion of rest for such cases he would add that of good feeding. In old days, when tertiary ravages were more frequent than now, he had seen cases go from bad to worse, in spite of the fullest doses of remedies. That was so especially in women. But when they began to have good food improvement ensued. A combination which was sometimes very valuable was bark or quinine, and opium, especially in the phagedenic form. He did not know why there should not be a combination of all those remedies. He would ask the medical man in charge of the case to start calomel injections at once.

CASE OF SUPPURATION IN BOTH FRONTAL SINUSES TREATED BY INTRA-NASAL METHODS, INCLUDING DILATATION OF THE INFUNDIBULUM BY MEANS OF BOUGIES (WITH SKIAGRAM).

Shown by Dr. DUNDAS GRANT. The patient was a gentleman, aged thirty-one, who had suffered from suppuration in the antrum and frontal sinuses, with headache, and difficulty in attending to his work. There were some polypi in the middle meatus, and the anterior extremities of both middle turbinated bodies were removed; the frontal sinuses were syringed out by means of Hartmann's cannula, with considerable benefit. What gave the greatest relief to the headache was the dilatation of the infundibulum by means of the curved bougies exhibited at the meeting. Subsequently the patient learned to introduce a curved Eustachian catheter into each frontal sinus; the position of the instruments *in situ* was shown by means of the skiagram. The patient had so far been free both from discharge and headache, but he still continued the irrigation. He is to present himself at the next meeting of the Society, when more complete notes of his case will be brought forward. (The bougies shown to the Society were made for the exhibitor by Messrs. Mayer and Meltzer.)

Dr. H. PEGLER said he was rather surprised that dilatation of the fronto nasal canal by graduated bougies had not been resorted to earlier by some rhinologists who were anxious to give a more lengthened trial to irrigation before having recourse to surgical means of a radical nature.

Mr. HERBERT TILLEY said he would have thought that mere dilata-

tion of a canal in that way would have but a temporary effect, one lasting only for hours. He thought the general experience would be that irrigation of such cases was very valuable if they could be got in the first month or two of the infection of the cavities. But after the disease had lasted a long time irrigation was not of much use. He tried it in many chronic cases before adopting external surgery, but he had only one case which was absolutely cured by it, namely six months ago, and the patient was still well. The injections used had included peroxide of hydrogen and almost all the ordinary antiseptics, including an iodoform emulsion, which was left in the sinuses for fifteen minutes, with the patient's head hanging over the edge of the table. Dilatation of the canal might be useful in enabling the surgeon to obtain freer entry into the sinus, but the canal would resume its shape a few moments after the withdrawal of the probe.

Dr. PEGLER, in answer to Dr. Tilley, said he conceived the possibility that the tumefied mucous membrane might yield to the effect of pressure by gradual dilatation and thus assist in the method of irrigation.

The PRESIDENT referred Dr. Grant to a similar skiagram which he exhibited when opening a discussion at Portsmouth on the treatment of frontal sinus disease. A fair proportion of frontal sinus cases could be cured by irrigation—*i. e.* where a larger cannula than an ordinary Hartmann's would be admitted. And it was interesting to notice how simply patients could be taught to irrigate their own frontal sinus. A young girl patient of his was doing it now, and last year he had a case with double frontal sinus disease which got well by irrigation. He also had a lady whose frontal sinus was full of pus, and she also was now quite well. He thought more cases of the kind were curable by irrigation than one was apt to think. In answer to Dr. Tilley, he said if patients did their own irrigation he recommended that it should be done twice a day.

Dr. PEGLER suggested that the success of the treatment would depend on the state of degeneration of the mucous membrane. If there were polypoid excrescences in the mucous sac, it would be all but impossible to cure it by irrigation. Was there any means of ascertaining the state of the mucous membrane of the frontal sinus before commencing radical surgical measures, as could sometimes be fairly accurately done in regard to the maxillary antrum?

Sir FELIX SEMON asked whether the question of the treatment of the frontal sinus was not in a sense analogous to that concerning the antrum. He would say emphatically that in his own experience when an opening through the alveolus had been established, and free drainage thus procured, the majority of the patients got well. Of course all depended, as Dr. Pegler had said, upon the condition of the mucous membrane of the affected cavity. If there was considerable polypoid degeneration, the cases did not get well. But he would vouch for irrigation being efficient if the cases were treated by it sufficiently early, and he did not see why the result should not be the same in the case of the frontal sinus.

Dr. J. B. BALL said he did not think the frontal sinus was quite analogous to the maxillary antrum from the point of view of treatment. He used to think that a great many cases of maxillary antrum suppuration could be cured by irrigation, but of late years he thought otherwise. The cases of dental origin were cured in that way when an opening was made in the alveolus and the teeth and stumps were attended to. But the real mucous membrane affection, which was analogous to most frontal sinus suppurations, did not get well, in his experience, with irrigation, unless it was of comparatively recent origin.

Dr. GRANT, in reply, regretted that the patient attended too late to tell his own history, but he had promised to come to the next meeting, and it would be seen how easily he could introduce the catheter into his own frontal sinus. He suggested that Dr. Tilley should reserve his judgment until he had given the method of dilatation by means of bougies a trial. Of course a comparison with the urethra would show points of analogy as well as of difference. There seemed no reason to condemn the principle, although practically it might have some disadvantages. If a patient were to penetrate the cribriform plate, it would be disastrous; the procedure must, therefore, be carried out very carefully. He had been pleased to hear the President's support of intra-nasal treatment, because he (Dr. Grant) had a weakness for it. In some cases, of course, he had to resort to the external operation, and the question was what means there were of knowing what was the condition of the frontal sinus lining in any particular case. He did not think there was anything very definite to go upon, unless numerous polypoid growths were found in the infundibulum, and then it was reasonable to suppose that the condition extended into the frontal sinus, though not necessarily. Some cases underwent almost spontaneous recovery after the removal of the obstructions. He agreed with Sir Felix Semon's remark concerning the antrum, that the cases were much more curable by irrigation than many observers supposed, but he did not think the irrigation should always be continued through the alveolar opening. Those who had found disappointment through the alveolar opening would find improvement or cure if they allowed the alveolar opening to close, and carried on irrigation through the perforation made through the inferior meatus. He hoped Dr. Ball would give the plan a good trial.

A CASE OF ULCERATION OF THE LEFT VOCAL CORD.

Shown by W. H. KELSON. The patient, a man aged twenty-eight, had suffered from hoarseness for about three months. There was no sign or history of syphilis, and the chest had been carefully examined, but nothing abnormal detected. On examining the larynx there was to be seen well-marked ulceration at the junction of the middle and posterior thirds of the left cord, the ulcer having thickened edges the right cord was normal. The mucous membrane of the larynx was anæmic. There were no enlarged glands to be felt. The question was as to the nature of the ulceration and, if tuberculous, whether primary or not.

Dr. McBRIDE thought the appearance of the left cord was typically tuberculous, though in the absence of bacilli it was difficult to dogmatise on the matter.

Sir FELIX SEMON, in reply to a question from the President, said that he was not prepared to formulate a definite opinion at first sight. If the man had been fifty-four years of age instead of twenty-seven, he would, in the first place, have thought of malignancy; there seemed to be too much thickening of the posterior part of the left vocal cord to be easily compatible with tuberculosis, though he did not, by any means, entirely reject the latter view. Of course the age of twenty-seven did not quite

exclude malignancy. He had himself seen a cylindriform carcinoma of the larynx in a man aged twenty-four. He would suggest that as soon as possible a small portion should be removed for microscopical examination.

Dr. A. BRONNER asked whether it could be a case of pachydermia with ulceration.

Dr. H. SMURTHWAITE said the posterior third was thickened and gave one the idea of a pachydermatous condition; but there was no depression on the opposite side, and the cord did not seem to be inflamed. If it were tuberculous, one would expect to find some inflammatory material beyond the ulceration.

Dr. KELSON expressed his gratitude for the suggestions offered, but he could not agree that the other part of the left cord looked normal. Around the ulcer there was a distinct reddened mass, which stood out in curious contrast to the opposite cord, which appeared to be normal.

Subsequent Note by Dr. Kelson.

On January 13, the day after the meeting, tubercle bacilli were found in the sputa, which were very scanty. The larynx having been cocaineised, the left ventricular band was raised with a bent probe, and it was found that the ulceration extended into the left ventricle as far as could be seen. The affected parts were then curetted.

CASE OF ULCERATION OF THE PHARYNX AND LARYNX.

Shown by Dr. BALL. The patient, a man aged fifty-one, was first seen at the end of last May. He had been complaining of very slight hoarseness and discomfort in the throat for two months. He had hawked up a little blood on three occasions. There was some swelling of the left side of the epiglottis and of the left ary-epiglottic fold. There was a small and rather superficial area of ulceration at the junction of the epiglottis with the left pharyngo-epiglottic fold. The glands in the left side of the neck were markedly enlarged. The patient was not seen again until last week. The glands in the left side of the neck were very much enlarged, and some enlarged glands were present on the right side also. Behind the left tonsil was an ulcer, elongated from above downwards, slightly raised, with hard base. The epiglottis was uniformly swollen and the left edge ulcerated, the ulceration extending on to the side of the pharynx. The ulceration in this region was not continuous with that behind the tonsil. There was no doubt about the case being epitheliomatous in nature. The points of interest seemed to be the very early involvement of the

glands, and the appearance of an ulcerating mass behind the tonsil, the disease having originated in the larynx.

Mr. BETHAM ROBINSON expressed the opinion that it was without doubt epitheliomatous.

The PRESIDENT said that a general hospital perhaps furnished more experience of such conditions than did a special hospital. It was not uncommon for patients to come with an enlarged gland in the neck long before any symptoms or difficulty in swallowing were noticed, in some cases even when one was unable to find ulceration by means of the laryngoscope.

Dr. SMURTHWAITE said he succeeded in catching a momentary glimpse of the larynx. The left half was turban-shaped, and ran into the middle of the epiglottis. It was semi-granular on the surface, and the ulceration looked like a superficial one, probably tubercular. The left tonsil was enlarged, and looked malignant, but he could not see any junction of infiltration between the epiglottis and the tonsil.

Dr. BALL, in reply, said the peculiarity was that it began in the larynx. He feared very few members got a view of the larynx. The epiglottis was swollen and on the left side there was a little ulceration near its junction with the pharyngo-epiglottic fold. It did not look unlike a tuberculous case in an earlier stage—that is to say, last May. The disease in the larynx was not quite continuous with that in the pharynx.

A MICROSCOPIC SECTION OF AN ANGIO-FIBROMA.

Shown by Dr. E. A. PETERS. This consisted of an irregular network of elongated branching connective-tissue cells, with rod-like nuclei and a granular cell matrix. Many young cells gave evidence of rapid growth. Interspersed among the network were dilated vessels of a venous type. The growth was removed from a boy aged seventeen. He had noticed left nasal inspiratory obstruction for three months. There was no history of bleeding. From the front a dark red fixed swelling could be seen pushing forward to the left middle turbinal bone. Under an anæsthetic an oval sessile tumour of about cartilaginous hardness and the size of a split tangerine was found to be present. It was attached to the periosteum of the basi-occipital and basi-sphenoid. The centre of the mass was the union of the basi-occipital and basi-sphenoid. The palate was split in the failure to adjust a snare, and the pharyngeal growth removed by clipping round the base with scissors. The nasal part was cut off by a sharp spokeshave and ring knife. The finger in the choanæ directed the blade and controlled hæmorrhage. The patient was in the Trendelenburg position during the operation, and made a good recovery.

Dr. PEGLER said it was a pity the growths could not have been exhibited *in situ*, because they were very uncommon. Only two had been recorded

by the Society, one of them being Dr. Herbert Tilley's. Under the microscope there was no doubt this was an angeio-fibroma, the greater part of the section being made up of fibrous tissue. There was very little literature on the pathology of these tumours of the nasopharynx.

The PRESIDENT said he thought the literature would probably be found under the heading of Pharyngeal Tumours, or Post-Nasal Fibroids. He believed many cases had been described, though possibly not microscopically.

Dr. GRANT asked whether the connection of the growth was completely made out. An interesting point brought out by Dr. Tilley and Dr. Fitzgerald Powell was that the growths seemed to find their way to some extent into the antrum. In a case of his own when he removed it he thought he got it clear away, but it recurred. On the second occasion he made sure by opening the antrum at the same time and scraping it away. Whether it grew from the antrum or not, it had made for itself a large opening in the inner wall of that cavity, and he would be glad to hear whether Dr. Peters' case had that peculiarity.

The PRESIDENT said he had operated upon several similar cases, and it was extraordinary how they absorbed the bony walls of the nose. He had removed them from the sphenoidal sinus and exposed the dura mater, and with success.

Dr. SMURTHWAITE reminded the members that he showed a specimen before the Society two years ago in which the whole of the septum and turbinal bones had disappeared. The large cavity thus made was occupied by polypus *in situ*, springing from the roof of the nose on the right side, and extended over to the left, pressing on the turbinals, which were also almost absorbed. The specimen had been obtained from the dissecting room.

Dr. JOBSON HORNE said he thought one reason why Dr. Pegler found a difficulty in following the literature of the subject was that such growths were formerly largely described under the heading of "sarcomata." They were innocent in course, killing only by pressure and destruction of adjacent parts, not by metastasis. In removing them the all-important point was to get to the mother part of the tumour.

Dr. PEGLER, in reply to Dr. Jobson Horne, said he drew a clear line between the hard growths and the softer ones which Dr. Horne referred to. He had touched upon the two forms of growth pathologically in a recent paper in the *Lancet*. The soft form simulated granulation tissue, and was often mistaken for sarcoma; the other, harder, growth was more angeiomatous, but was closely related to fibroma in his belief.

Dr. PETERS, in reply, said the growth was very hard—almost cartilaginous to the finger and scissors. It apparently was attached by a wide base to the periosteum of the basi-occipital and basi-sphenoid to the left of the median line. It had pushed over the vomer to one side and the left middle turbinal forward.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND THIRD ORDINARY MEETING, *February 2, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B. } Secretaries.
W. JOBSON HORNE, M.D. }

Present—30 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

ELECTION OF ORDINARY MEMBERS.

The following gentlemen were elected as Ordinary Members of the Society—

A. LIEVEN, M.D., Aix-la-Chapelle.
ARTHUR EVANS, M.S., M.D.Lond., F.R.C.S.
G. IRVINE STEWART, M.B., Aberdeen.

The following communications were made :

CASE OF LARYNGEAL ULCERATION IN A MAN AGED FIFTY-FOUR.

Shown by Dr. DONELAN. The patient had suffered at intervals from some pain on swallowing for the previous six months ; he was first seen about three weeks ago, when there was an ulcer on the right ary-epiglottic fold. On seeing the patient again that evening a remarkable extension of the ulceration on to the pharynx had taken place. There was no history of syphilis, but anti-syphilitic remedies had been tried. The opinion of the Society was desired as to the nature of the case, and if it were considered malignant whether any operation should be attempted.

Mr. C. A. PARKER thought the swelling was on the posterior wall of the pharynx, not on the tongue. He regarded it as a gumma breaking down on the right side.

Dr. H. J. DAVIS thought, with Mr. Parker, that the condition was a gumma, especially as the patient experienced no pain in swallowing, and

this he regarded as evidence of its being syphilitic rather than tubercular or malignant.

The PRESIDENT asked whether Dr. Donelan had administered any anti-syphilitic remedies in the case.

Dr. DONELAN, in reply, said the ulceration to which he wished to call attention in the first instance was on the right ary-epiglottic fold, which existed three weeks ago. Since then he had had no opportunity of making a laryngeal examination until that evening, and saw the remarkable extension of the ulceration on the posterior wall of the pharynx for the first time. The history of the case extended back about six months. There was no history of syphilis, but the patient had taken ten grains of potassium iodide and a drachm of perchloride of mercury three times daily for three weeks with no apparent beneficial effect. He had been anxious to know whether any member would suggest any operation.

CASE OF EXTENSIVE SYPHILITIC ULCERATION IN THE PHARYNX OF A
MAN AGED TWENTY-EIGHT, TREATED BY CALOMEL INJECTIONS;
ILLUSTRATING RAPID IMPROVEMENT IN THE PATIENT.

Shown by Dr. DUNDAS GRANT. The patient had presented himself again to show the very gratifying improvement which had taken place, and which had started within a few days after the first injection of calomel, recommended by Dr. Lieven, and favourably referred to by Sir Felix Semon in a lecture recently published.¹ The result had answered fully to Dr. Lieven's expectations.

The exhibitor had recently had under his observation several cases of specific disease of unusual severity, one in which a young gentleman, otherwise in good health and in favourable surroundings, had suffered from numerous rupeal spots explained by a dermatologist as due to the superposition of staphylococcus infection on the specific one. The same patient had had up till recently an oedematous condition of the left half of the epiglottis and left ary-epiglottic fold. Dr. Grant desired to learn whether members of the Society had observed that specific infection was at present of a more severe type than in previous years.

The PRESIDENT said all would be willing to congratulate both Dr. Grant and the patient upon the immense improvement which had taken place in the interval. He would like to hear what amount was injected and the site chosen.

Dr. GRANT replied that the injection was done in the supra-external quadrant of the buttock, the area marked out by Dr. Lieven for the purpose. He used 15 m of a 1 in 10 suspension of calomel in paroline. It was done twice a week; it certainly caused some discomfort.

Dr. W. H. KELSON joined in congratulating Dr. Grant on the success of the case, but before commencing to inject obstinate cases of syphilis

¹ *Brit. Med. Journ.*, January 13, 1906.

with calomel he would like to know whether it were true that there had been some disastrous results from this method of treatment.

Mr. PARKER called attention to a recent paper in the *British Medical Journal* by Lieut.-Col. Lambkin, based on an experience of 3000 cases treated by 60,000 injections of mercury in some form. He had found calomel very active, but painful, and apt to set up painful nodules and swellings at the site of injection. He prefers mercury itself suspended in lanolin as being gradually, evenly, and slowly absorbed. After injecting it some 40,000 times he is able to state that he has seen no serious complication of any kind.

Dr. GRANT, in reply, said a paper was published some time ago suggesting that gummata were apt to form at the site of injection of insoluble preparations of mercury, but it seemed to be a very rare occurrence. Dr. Lieven recommended the treatment so confidently that he (Dr. Grant) tried it, and felt indebted to that gentleman in consequence. The discomfort was very small. There was an original paper in the *Journ. of Laryngol., Rhinol., and Otol.*, in which Dr. Lieven¹ described his methods of treating syphilis of the upper air-passages.

Dr. H. J. DAVIS said the interesting point was this: When Dr. Lieven first saw the case he stated that he did not think it would improve with mercury or iodide of potassium, but that he was certain it would improve with injections of calomel. There had been, so far, only six injections, and yet the patient was practically well.

Dr. GRANT, in further reply, asked whether other members had recently seen cases of syphilis of a greater severity than during the last ten or fifteen years. He had seen several.

SONDERMANN'S SUCTION APPARATUS.

Shown by Dr. DUNDAS GRANT. This consisted of a nose-piece with pneumatic borders and an indiarubber bulb with valves so constructed as to only exercise suction. With this he had been able to relieve discomfort by the withdrawal of secretions from the sinuses of the nose. He described a case to which he had been called that same afternoon; the patient complained of excruciating frontal headache of considerable duration. There was seen in the right middle meatus some creamy pus, but the left one was hidden by a swelling of the middle turbinated body, the frontal pain being greater on the left than the right side. After spraying with cocaine and adrenalin, the patient was instructed to hold his nose and make an expiratory action, but this produced little or no effect, whereas when Sondermann's apparatus was applied, while the patient uttered the sound "ee" or "kee," a purulent secretion was extracted and then snuffed back into the throat and spat out. The patient then found himself considerably relieved. The exhibitor considered the instrument a useful auxiliary in the treatment of such cases.

¹ *Journ. of Laryngol., Rhinol., and Otol.*, vol. xviii, p. 225.

CASE OF SUPPURATION IN BOTH FRONTAL SINUSES TREATED BY INTRA-NASAL METHODS, INCLUDING DILATATION OF THE INFUNDIBULUM BY MEANS OF BOUGIES (WITH SKIAGRAM).

Shown by Dr. DUNDAS GRANT. The patient, a gentleman aged thirty-one, was first seen by the exhibitor in November, 1902, when he complained of daily attacks of dizziness and headache, which he had suffered from for the previous two years, the discomfort being worse after stooping down over his work. Both antra were punctured and the left one was full of pus; there was also a swelling of the anterior lip of the hiatus semi-lunaris and probably suppuration in the frontal sinuses. The next day he was more free from giddiness than he had been for two years. The antrum was punctured through the alveolus, and the patient himself regularly carried out the treatment by irrigation for a number of months, during which he experienced a slight improvement. In September, 1903, he was still conscious of an offensive smell in the nose, and this was worse in the morning. The anterior portions of the middle turbinated bodies were removed, and this was followed after a fortnight by some diminution in the amount of discharge. The frontal sinuses were frequently washed out, at first with glycothymoline and then with a weak solution of formalin, 1 in 4000, then in 1 in 2000 and 1 in 1500. In May, 1904, Messrs. Mayer and Meltzer made for the exhibitor some S-shaped bougies for dilating the infundibulum, and these were used up to the fourth size. Almost immediately after this treatment was started, the headache became so slight that he reported it as quite gone. He soon learned the art of introducing a curved cannula into his frontal sinuses for himself, and had been out of Dr. Grant's hands since the middle of 1904. The skiagram showed the cannula in position.

SUPPURATION OF FRONTAL SINUSES TREATED BY IRRIGATION ONLY.

The PRESIDENT showed the case of a man aged thirty who came under his care for suppuration in both maxillary sinuses, both frontal sinuses, and ethmoidal sinuses. The maxillary sinuses were drained through the alveolus. As a large sized cannula could be passed into the frontal sinuses they were, after removal of a part of the middle turbinal, irrigated. The patient learnt to irrigate the sinuses himself with great facility, and as he had a

considerable objection to any external operation this method was continued; after about six months he returned without any pus being washed out. He had not been seen for nine months, and was shown that day as a patient who had reported himself a few days before as well. On examination it was found that there was pus in both nostrils. This the patient attributed to a cold, but the appearance suggested that there was a recurrence of suppuration, or possibly it never got quite well. The patient, however, demonstrated the fact that it was possible for the sinus to be washed out with great facility, and that at least the suppuration could be reduced to a minimum, and, as other cases had shown, might be completely arrested.

The PRESIDENT said there could be no doubt that his patient had got pus in his nose. The man, who was somewhat careless of his condition, thought it was due to cold. He had not seen the patient for nearly a year.

Dr. DENNIS VINRACE said all would welcome conservative surgery in such cases. He asked incidentally whether the patient was correct when he said he passed the catheter himself the first time. He presumed there was some preliminary operation.

The PRESIDENT, in reply to Dr. Vinrace, said the patient must have meant that he succeeded in passing the catheter the first time he tried. But, of course, he showed him two or three times how to do it.

Mr. E. B. WAGGETT said that the success or failure of treatment by irrigation seemed to depend upon the size and shape of the frontal sinuses. He had many cases treated by this method, the patients using a cannula daily. They did very well and were relieved of symptoms, but, with two or three exceptions, he had not seen a real cure.

Mr. HERBERT TILLEY thought the point raised by Mr. Waggett was a very important one. Another determining factor in the successful termination of any case was the extent to which the neighbouring ethmoidal cells were involved. If the contour of a frontal sinus was fairly regular, and the opening into the nose was free and blocked neither by the middle turbinal nor by large granulations around the anterior ethmoidal cells, that sinus ought to be curable by irrigation and free drainage. But if near the opening of the sinus into the nose there were small suppurating ethmoidal cells which were constantly re-infecting the sinus, one could not expect irrigation to produce a successful result. An excellent illustration of that had recently occurred in a medical friend who had been under his (Mr. Tilley's) care during the past ten days, and who had frontal sinus suppuration. The sinus could be easily irrigated, and this was carried out once daily for a week, but the pain in and around the eye was so great and unrelieved by the irrigation that the sinus was opened, and it was found that although it had been irrigated and was comparatively healthy, yet on the floor of the sinus and near its inner end was an ethmoidal cell from which pus exuded when its cavity was probed. There were other ethmoidal cells under the sinus, and those extended back between the eye and the floor of the frontal sinus as far as the sphenoid. Having made a large opening into the nose and destroyed the cells referred to, the headache disappeared, and he had had

no trouble with the patient since. He sewed up the external wound at once, and had done this in the last four cases which he had operated on during January. Thus one not only cleared the sinus, but those most important ethmoidal cells near its floor were destroyed, so that with immediate closure of the external wound such cases might be discharged in a fortnight. He proposed to show four patients at the next meeting who had been dealt with in the manner described.

Mr. CHICHELE NOURSE said that the treatment of frontal sinusitis through the infundibulum had been a subject of interest to him for some years. He spoke of it at the Portsmouth meeting in 1899. He had been in the habit of using probes and cannulæ considerably more curved than those now shown. He had tried irrigation with various liquids, but had never quite succeeded in curing a case by that means. The substances he had found of most value for injection were menthol-valsol (a petroleum preparation) and peroxide of hydrogen solution. In three or four cases he had also tried the plan of introducing a small drainage-tube through the infundibulum by means of a probe shaped like the one he exhibited, upon which two pieces of drainage-tube were threaded. The second piece of tube was used to push the first one onwards into its place. On withdrawing the probe, the first piece of drainage-tube was left in the sinus with the end hanging into the nose. At first too long a piece was used, and the patient complained of the free end moving in his nose as he breathed. Accordingly it was gradually shortened. Once it was found to have disappeared entirely into the sinus, but was dislodged by syringing with the oily preparation mentioned above. It was re-introduced and the patient continued to wear it for some time, but eventually it disappeared again, and could not be brought down. As the suppuration was not cured, the sinus was opened in the usual way, and the tube was found lying within it. In subsequent cases he used somewhat longer tubes. After a small tube had been worn for some days, he found that the fronto-nasal canal would admit one of a larger size. However, although it was easy to carry out, he had not found any great advantage gained from this plan. In order to judge whether the probe was in the sinus, a second probe of exactly the same curve and size was laid parallel to the first along the outer side of the nose. On one occasion when performing a radical operation on the frontal sinus, he had introduced one of these probes beforehand through the infundibulum and was able to bring the point out of the frontal wound by depressing the handle. The peroxide of hydrogen solution he used was of the usual strength diluted to one in three.

Dr. SCANES SPICER said he was interested to hear of the reversion to conservative methods. He had always felt rather conservative about the frontal sinus, probably because drainage being so much easier there than in the other sinuses one gave sufficient relief by removing the anterior part of the middle turbinate, freeing the infundibulum and anterior ethmoidal cells so that the sinus was sufficiently drained and improved by intra-nasal operations. He thought unnecessary stress was being laid on intubation of the frontal sinus. If the contents of the anterior ethmoidal cells were thoroughly cleared away, sufficient drainage was usually obtained without actual intubation, which introduced the danger of new or re-infection. At the same time, one must not hesitate to adopt the course Dr. Tilley had rendered popular in cases where there were periodical daily recurrent headaches in which efficient drainage could not be obtained by intra-nasal measures, also where there was septic infection

of the frontal bone, with pain, swelling, and redness externally. There were cases needing external operation in addition to the previously carried out intra-nasal measures. One had had cases under local treatment for many years in which one had become bound eventually to recommend the radical operation. He was very interested in the skiagrams of the tubes *in situ*, though he had not yet felt impelled to get any done of his own cases. With regard to Sondermann's apparatus, he (Dr. Spicer) found one could often exhaust the accessory sinuses, suck out the antrum and frontal sinus by clamping the nose and inspiring strongly with shut mouth. He therefore did not see offhand the need of an apparatus for doing this.

Dr. F. W. BENNETT pointed out that whereas it was difficult to pass a probe into the normal frontal sinus in the case of chronic suppurative lesions it was possible to do it in more than 50 per cent. It could be learned by the patient and easily carried out.

Dr. GRANT, in reply, called the attention of members to the usefulness of the bougies employed in the present case, which he described last time and which aided in preparing the patient for the cannula. Dr. Tilley had well expressed the conditions which one might expect to cure by the treatment. He (Dr. Grant) found quite a sufficient number to encourage such a procedure.

The PRESIDENT, in reply, said that in a certain number of cases where there was pure frontal sinus disease it seemed possible to effect a practical cure. The present case did not represent cure, but the frontal sinus sometimes did get well, even with the removal of the anterior end of the turbinal. He had seen the pus disappear after a couple of washings, and had watched for recurrence without it happening, showing that it was possible for slight cases to recover in that way. In more advanced cases of ethmoidal disease it was necessary to open them up. In answer to Dr. Tilley, he had obtained better results by sewing them up immediately. The present man was operated upon three and a half years ago, and the sinus was washed out through the nose.

CASE OF FIXATION OF RIGHT CRICO-ARYTENOID JOINT DUE TO INFILTRATION, PROBABLY MALIGNANT DISEASE, IN A WOMAN AGED FIFTY.

Shown by Dr. FURNISS POTTER. The patient gave a history of pain and difficulty of swallowing for the last six months, and stated that during this time she had become thinner, otherwise her health had been good. There was no cough and no affection of voice or respiration, no evidence of syphilis. On laryngoscopic examination the region of the right arytenoid cartilage and ary-epiglottic fold was seen to be reddened, swollen, and cedematous. The crico-arytenoid joint was fixed in about the middle line, though on inspiration a flickering movement of the cord was observable which gave an impression as if fixation were not complete; on careful inspection, however, no true movement of the arytenoid could be seen. Examination by the finger gave no sensation of hardness. An

indurated gland could readily be felt immediately behind the angle of the jaw. The chest had been examined with negative result.

During the last few days the patient had complained of considerable pain radiating from the throat to the ear. Potassium iodide had been taken for the last ten days with no appreciable effect.

Sir FELIX SEMON said it was almost impossible to give an opinion on account of the œdema of the arytenoid. But owing to the large gland in the corresponding side and the fixation of the cord, he thought the probabilities were in favour of malignant disease rather than tuberculosis.

Dr. GRANT said the case was almost on all fours with one he showed some time ago, with swelling of the right epiglottic fold, fixing the cord. In the present case the cord was, however, not quite fixed. In his case there was difficulty in swallowing, and he thought at first it was syphilitic perichondritis, but the President's suspicion that it was an extrinsic carcinoma of the lower part of the pharynx and larynx turned out correct. The glands in the present case supported the idea of malignant disease. Perhaps if a definite diagnosis was urgently called for there would be little difficulty in removing one of these glands for microscopic examination.

Mr. WAGGETT said that as œdema was also present on the left side of the cricoid the case was very likely to prove an œsophageal carcinoma; the œsophagoscope should be used before anything further was done.

The PRESIDENT said the case looked like one of epithelioma behind the cricoid, extending up under the mucous membrane. Possibly there would be sprouts of growth there before long.

Dr. FURNESS POTTER, in reply, said the remarks which had been made confirmed his own suspicion. He regarded operation as so much out of the question that he had not mentioned it.

CASE OF INTRINSIC LARYNGEAL NEOPLASM IN A MAN AGED SEVENTY-THREE, SHOWN AT JUNE MEETING, 1905.

Dr. SCANES SPICER described the surface of the anterior half of both cords as covered with dull, rough, patchy areas of yellowish-white colour (? ulceration), with tiny nodular masses projecting, especially on the left cord. There was a slight huskiness, but no cord-paresis, pain, cough, dyspnoea, dysphagia, bleeding, tumour, cachexia, or enlarged glands. The appearances, plus the microscopic diagnosis of papilloma previously made, did not justify the clinical diagnosis of malignancy or call for laryngo-fissure, nor did it appear wise to irritate the larynx by intra-laryngeal measures. The picture was a peculiar one, and as he himself did not grasp its exact significance he would be glad to hear the opinion of the Society.

Sir FELIX SEMON said that if he had seen the case now for the first time his idea would have been that it was a mycosis, not new growth. He suggested that a piece should be again removed for microscopic examination.

Dr. H. PEGLER said the extreme whiteness was explained under the microscope by the character and density of the layer of keratinous cells that covered over the peak-like apices of the papillomatus growth.

The PRESIDENT regretted he had been unable to bring before the Society a lady who showed a similar condition. On the left vocal cord was an irregular nodular growth of peculiar whiteness, but with a movable vocal cord. She had had a similar patch on the right cord, a portion of which was removed and reported to be malignant. This growth had entirely disappeared from the right cord, and without operation. The patch on the left cord was like that in Dr. Spicer's case, only of less degree; it had been present for a year. He would again try to bring the case for inspection.

Dr. Grant pointed out that an almost identical case was illustrated in Krieg's *Atlas*. It was shown there as non-malignant proliferation of the superficial epithelium—a kind of pachydermia or keratosis.

Dr. SCANES SPICER, in reply, thanked members for their suggestions. It did occur to him that the surface appearance resembled mycosis in the tonsil, but in view of the large papilloma which had been removed, and the subsequent ulceration and thickening, and not remembering to have met with mycosis of vocal cords, or read of it, he had not seriously entertained that view until suggested to him by Sir Felix Semon. Perhaps there was a mycotic growth arising on the nidus of the ulcerated papillomatous base. Anyhow, he would remove a small piece, with the patient's consent, and get it examined from that point of view. He was gratified that the Society agreed with him that the appearances and symptoms were not sufficiently those of malignancy to justify an external operation.

A PEDUNCULATED GROWTH OF UVULA IN A BOY AGED NINETEEN.

Shown by Dr. W. H. KELSON. The patient came complaining of running from the nose and was unaware of the presence of the growths, one of which was about the size of a pea, the other of a broad bean, and both were growing from the base of the uvula. They both had pedicles and appeared to be papillomata.

The PRESIDENT asked if they were attached to the base of the uvula. These growths he had not infrequently seen, and had looked upon them as harmless.

Sir FELIX SEMON said that some years ago Mr. Stephen Paget rather alarmed the profession by insisting on the possible malignant transformation of such growths, and since then he (Sir Felix) had, as a matter of precaution, removed them. But he regarded the danger of transformation as exceedingly remote.

CASE OF EPITHELIOMA OF THE NASO-PHARYNX, WITH MICROSCOPIC SECTION.

Shown by Mr. STUART LOW. The patient, a man aged forty-four, complained merely of slight deafness in both ears of recent

date. On examination, the soft palate was found to be almost motionless, and in the naso-pharynx a large raised ulcerated surface was discovered on the posterior wall. On palpation this was felt to have a very firm outline and base, giving an almost horny feeling in places. It was ulcerating at certain parts, and bled freely when touched. The naso-pharyngeal canal was felt to be greatly narrowed, and the induration had infiltrated the lateral wall on the left side and the posterior palatal pillars. The hard outline of the growth could also be plainly made out through the soft palate on backward pressure with the finger. There was an entire absence of glandular enlargement. The absence of subjective symptoms was remarkable. There was no discomfort in breathing or swallowing, no pain, no nasal obstruction nor nasal intonation. He said that he had lost a stone in weight in three weeks, and since coming under observation fourteen days ago he had lost half a stone. He had worked for years in a very foul and very dusty atmosphere, being a cleaner and sweeper of railway carriages. His wife had been for some months in a lunatic asylum, and this had worried him very much. He had had a great deal of domestic work to do in addition to long hours of labour, having five young children at home, and being too poor to pay anyone to attend to them. The family and personal history threw no light on the case.

Schmidt had reported having found one case of epithelioma in forty of naso-pharyngeal tumours, but a Spanish writer had recently found as many as five in twenty cases. There was a noticeable predilection for the male sex in these statistics. Mr. Stuart Low remarked that the inveterate cigarette smoking with nasal exhalation of the tobacco smoke by the Spaniards might help to account for this prevalence.

The man was now on 20-gr. doses of iodide of potassium three times a day, but was still losing weight. Mr. Stuart Low asked for the opinion of the members on the feasibility of operation. A piece of the growth had been removed for microscopical examination, and Dr. Wyatt Wingrave had given the following report; the specimen would be submitted to the Morbid Growths Committee for their opinion.

Report by Dr. Wyatt Wingrave.

The growth consists chiefly of closely-packed epithelioid cells channelled in varying degrees by microblastic tissue, so that it is loose in texture in some parts, almost solid in others.

The cells are round, fusiform, or oval, according to their respective position or compression, their nuclei being round or oval, according to the axis of section; several exhibit very irregular, mitotic forms.

The mesoblastic stroma consists of white fibres with leucocytes and lymphocytes, supporting blood- or lymph-vessels whose walls are thickened by fusiform cells. In some parts the lymphocytes are very numerous, and there are groups of multinucleated masses which are probably "fusion" cells.

The growth probably originated in the peri- or endothelium of these vessels, since in some parts the perithelial cells are not only thickened, but appear to be traceable into the neoplastic elements.

It differs from ordinary squamous epithelioma in that there is no tendency to concentric lamination or "nesting" of the cells, and they do not exhibit any horny or keratin changes.

The PRESIDENT thought there could be little doubt as to the nature of it. He could not recall many instances of it, but two were quite familiar to him, both inoperable. One of them came with a lump in the neck, but no complaint about the throat. He found carcinoma in the naso-pharynx. He had many sections of rodent ulcer from various parts of the body, and Mr. Low's section resembled some of them. It demonstrated the importance of post-nasal examination in deafness.

Dr. PEGLER said there was a strong suspicion of malignancy about the case, but the Morbid Growths Committee would report.

CASE OF INJECTION OF COLD PARAFFIN FOR NASAL DEFORMITY.

Shown by Dr. DUNDAS GRANT. The patient, aged twenty-four, was the one whose photographs were brought before the Society in January, 1904, after he had had subcutaneous paraffin injections for rectification of the deformity due to a depression of the bridge of the nose, resulting from injury seven years ago. The improvement in the appearance was then considerable, and as long as he continued in his occupation of ship's steward it appeared to be lasting. Unfortunately, in spite of having been strictly advised to avoid exposure to heat, he became a stoker in the Royal Navy, and was exposed to temperatures of as high as 180° Fahr. The paraffin appears to have yielded and the nose returned to its previous shape. He came under observation again a week ago, and was at once treated by means of an injection of cold friable paraffin by means of Mahu's syringe, the result for the moment being extremely satisfactory and the patient having decided to give up his occupation of stoker, Dr. Grant had some hopes that it

might be lasting. He would be glad to know what had been the ultimate results in the experience of those who had observed such cases, and he proposed inquiring with regard to the few cases he had had under his own treatment, and reporting to the Society. Meanwhile, he recommended the ingenious instrument devised by Mahu, which was a modification and, in his opinion, an improvement upon the original one of Broeckaert, and which, until the invention of a better one, was most probably the most perfect at their disposal. The friability of the paraffin was an important point, inasmuch as it allowed of the breaking off of the thread inside the subcutaneous space instead of its remaining and forming a plug in the needle-puncture in the skin.

Sir FELIX SEMON said he was not an inveterate opponent of any good innovation in surgery, but he would read a translation of the peroration of a recent article by Dr. L. Kirschner, of Berlin :

"It is easy to see the importance of the results gained by these histological investigations with regard to treatment. We have seen that neither of the two kinds of paraffin which are used nowadays therapeutically, neither the hard nor the soft paraffin, belong to the foreign bodies which, subcutaneously injected into the organism, 'heal in'—i. e. heal in in that sense that they form a capsule, which separates them from the rest of the tissue. We must remember that we include under the expression 'healing in' various pathological processes. To choose a ready example—when we use a catgut thread, we understand by its healing in its complete resorption; of a lead bullet, on the other hand, we expect that it heals in by surrounding itself by a connective-tissue capsule in the shape of a mantle. In the one case, therefore, healing in means complete resorption and assimilation of the substance which it is intended to heal in; in the other case it means its complete preservation.

"What kind of pathological process is the injected paraffin intended to produce in order to be therapeutically effective? The injected paraffin is intended to repair deformities, fill up defects, replace, so to say, lost tissue, support sunken-in structures, etc. This task could be lastingly solved by paraffin only if after injection it remained *in loco unchanged in extent and consistency*, if, as has been erroneously supposed, it became encapsulated. We have just seen that the reverse is the case. We may, however, go even further. It would be quite conceivable that the commencing organisation, that is to say, the perforation of the paraffin by connective tissue which unavoidably follows the injection, might be considered as a very desirable process, advancing the therapeutic object. But, as we have seen, the connective-tissue organisation does not become arrested at any given moment; it irresistibly proceeds, following its own laws; it leads to *complete resorption* of the foreign body which has been introduced. Further, we have seen that *both kinds of paraffin* are not at all *lastingly tolerated* in several parts of the body in which they are used with predilection, because they produce severe local tissue disturbances which render their *premature removal* necessary. But even where this does not occur, and where paraffin is being tolerated for some length of time without doing harm to the neighbourhood, a brief consideration of the fate of the young connective tissue which becomes developed during the organisation of this foreign body, viz. the unavoidable change of the inflammatory tissue produced into a shrinking scar, must show more distinctly than anything else how fallacious are the therapeutical surmises which have led to the use of paraffin."¹

The practical conclusion to be drawn from this seemed to be that every surgeon who had made a large number of such injections should ask all his patients some years later to show themselves, so that an opinion could be formed as to the lasting effect of these injections. From

¹ Virchow's Archiv, Bd. 182, Heft 3.

the mere fact that failures had not oftener been reported it was obviously unsafe to draw conclusions as to the stability of the primary effect. It was certainly possible that some had been unsuccessful and that the patients had consulted other advisers. He suggested such an inquiry by members of the Society.

Dr. DONELAN said he had had a case over two years ago which illustrated some of the points referred to. A young man had fractured his nose, leaving a saddle-shaped depression. Paraffin of 112° F. melting point was injected. He was quite pleased with the result as regards the nose, but owing to the fracture some of the paraffin worked out at the level of the lower border of left nasal bone forming a curious ridge on the cheek. Every form of heat that could be devised without blistering the cheek was tried so as to alter the shape of this "spur" without effect. At length it was dissected out under aseptic conditions, leaving practically no mark. Under the microscope sections of the removed "spur" showed that it existed in a finely granular condition intimately diffused through the connective tissue. He had used the instrument shown by Dr. Grant to inject the inferior turbinals in a case of atrophic rhinitis. It was much simpler and cleaner than the hot paraffin injections, but he thought the melting point of the paraffin charges was much lower than the degree claimed for them.

Dr. SCANES SPICER reminded members of the case he had shown at this Society, January 10, 1902, with models and photographs before and after, (Cheltenham Meeting, British Medical Association, 1901), the first case of the kind done in England, and the results of which some might remember. In this first case, although the improvement in contour remained, within a year the paraffin wandered into the eyelids, causing œdema of these to the extent of closing the palpebral fissures, with interspersed solid nodules. Not liking to undertake a dissecting operation in the eyelids, he asked his colleague, Mr. Juler, to remove these nodules, and the result was a perfect recovery. He had sections showing paraffin diffused in a molecular spheroidal form; diffraction bands were seen all round the globules imbedded in dense connective tissue. He had injected seven or eight cases altogether, but he became disappointed with the procedure chiefly because of the scalding of the patient by the heated injection cannula and the subsequent pain; in fact, after the first case an anæsthetic was always needed and given. One lad from the country he injected three or four times, and the result was especially unsatisfactory, as the points of injection suppurated in spite of antiseptic precautions, and the shape of the nose remained as before. The use of solid paraffin appeared to be a great improvement. In suitable cases, especially in young women who had the extreme saddle bone of congenital syphilis, he thought paraffin injection would remain a legitimate and useful procedure. He did not think anyone should attempt it for minor degrees of irregularity or to gratify a whim—to convert an ordinary into a Roman or Greek profile. It would be observed that in Dr. Grant's case, as in his own and in most other operators' cases, the result could hardly be described as refined or elegant. He would therefore limit the use of paraffin injection into the nose to cases of gross deformity.

Dr. VINRACE supported the suggestion that those who had adopted the method should report on their cases after a substantial interval. He said it should be borne in mind that these operations were not done in conditions which threatened life, and even from the sentimental point of view he did not know that it was right to give to a girl a semblance

of beauty by which to deceive the opposite sex. He had not yet seen an instance of the operation where it seemed to have been justifiable, and he would be delighted to see cases where it had been done some years ago with satisfactory and permanent results.

Sir FELIX SEMON desired to ask why, when a quantity of this new cold and soft paraffin was injected into the nose, or any other part, it was supposed that the paraffin would remain stationary, as moulded by the surgeon at the operation? When the paraffin was put from the bottle into one's hand it could be moulded to any form. He would have thought that even such pressure as that exerted by a pillow at night time on the nose would interfere with its form, and, of course, much more so a blow or fall, causing more serious disfigurement than had existed before the injection had been made.

Dr. GRANT replied that it was his intention to get the records of such cases. He had not done many of them. He did not think anybody professed that the form of paraffin he had just shown would be more solid or even as solid as those with a higher melting-point. The great point was the immense convenience of being able to inject it without heating and without scalding the patient. It could be done under cocaine. It had been said that the ease with which it could be done would enable quacks to do it, but that was scarcely a scientific objection. As to the propriety of having it done, if one were similarly disfigured oneself one would be glad to have it used, and that was surely a good reason for giving others the benefit of it, even if at the end of two years it might have to be refreshed again. The method must be tested in the calmest way possible, and he proposed to bring forward his cases for his own and the Society's inspection.

SUPPURATION OF THE LEFT FRONTAL AND THE LEFT MAXILLARY SINUSES. CLOSURE OF THE WOUND AND IRRIGATION.

Shown by the PRESIDENT. A man, aged forty, was brought to me in June, 1900, by Dr. Hugh Smith, of Highgate, who had drained the left antrum through the alveolus for empyema. Recovery not taking place, I removed the anterior end of the middle turbinal, and irrigated the frontal sinus, finding it full of pus. Dr. Gregory carried out irrigation of the frontal sinus, and introduced iodoform without effecting a cure. In December the frontal sinus was opened above the left brow, the lining membrane was entirely removed, the opening into the nasal cavity enlarged, the middle turbinal was next removed, the antrum was opened through the incisor fossa and an opening made from the cavity into the inferior meatus, a part of the inferior turbinal being removed. The frontal sinus was irrigated daily, and primary union took place. The nasal suppuration had been of eight years' duration, and no recurrence had followed the operation. He was shown chiefly to indicate the small amount of scar and the success of the method adopted. Mr. Symonds referred to this method as

superior to that of packing or the use of drainage-tubes in the nose and said that it was the plan he usually adopted. He had found some years ago that drainage was unsatisfactory by rubber tubes, and that packing led to infection of the skin and recurrence of suppuration. It was also pointed out that the anterior wall was not completely removed, but only sufficiently to give free access to every part of the cavity, and to enable a free opening into the nose to be made.

PROCEEDINGS
OF THE
LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND FOURTH ORDINARY MEETING, *March 2, 1906.*

P. WATSON WILLIAMS, M.D., Vice-President, in the Chair.

HENRY J. DAVIS, M.B.
W. JOBSON HORNE, M.D. } Secretaries.

Present—28 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

NOMINATION OF ORDINARY MEMBER.

E. TAIT ROBINSON, M.D., M.Ch., R.U.I.,

was nominated for election as an Ordinary Member at the next meeting of the Society.

The following communications were made :

CASE OF TUBERCULOUS LARYNGITIS REMOVAL OF EPIGLOTTIS ; CURE.

Shown by Mr. HAROLD BARWELL. A. G—, a girl aged twenty-one, first seen by me in July, 1905, had had extensive disease of the left upper lobe six years before, and later the right lung became involved. On admission there was impaired resonance at the right apex, back and front, with crepitations and increased vocal resonance; on the left side there were moist sounds behind and in front down to the mid-scapular level, high-pitched dulness, increased vocal resonance, and, near the left side of the spine, whispered pectoriloquy. There was then no expectoration, but tubercle bacilli had been found in January, 1904, and again when, after the larynx had healed, she went to the sanatorium at Northwood. She had been hoarse for five weeks and had suffered for three weeks from

dysphagia, which had become so severe that she had been unable to swallow solids for some days. The epiglottis was much infiltrated and ulcerated on its laryngeal surface; the remainder of the larynx was unaffected. The epiglottis was removed with punch-forceps in two pieces; the dysphagia was at once relieved, and the wound healed rapidly. The larynx remains well over six months after the operation, and the general health has much improved.

CASE OF TUBERCULOUS LARYNGITIS; ACTIVE LOCAL TREATMENT; CURE.

Shown by Mr. HAROLD BARWELL. The patient, a woman aged thirty, was admitted to Mount Vernon Hospital, Hampstead, in May, 1905; she had suffered from weakness of voice and cough for fifteen months, and there were occasional streaks of blood in the sputum, in which tubercle bacilli were also found. Diminished resonance and moist crepitations over the left upper lobe in front and behind. The right arytenoid was congested and swollen, the right cord was reddened, and there was interarytenoid swelling; the left arytenoid was also slightly swollen. Daily frictions were employed, with a mixture of lactic acid, formalin, and carbolic acid, and a week later a piece of the right arytenoid was clipped away with Lake's forceps. The frictions were continued and the larynx became completely healed. The patient stayed at the Northwood Sanatorium from July 7 to August 9. She is now in service; the scar of the operation is just visible, but otherwise the larynx appears normal.

Mr. E. B. WAGGETT congratulated Mr. Barwell heartily on his excellent result, particularly in respect to the epiglottis case, which seemed to be absolutely cured. His experience was that tuberculosis of the epiglottis was very apt to resist the good influence of sanatorium treatment, and amputation of it, which had been done a number of times, was, he believed, a very valuable therapeutic proceeding. Some patients refused to submit to the operation under cocaine. A few days ago he had amputated the epiglottis under chloroform anæsthesia, the patient sitting in a chair. Adrenalin and cocaine were employed in addition. No difficulty whatever was experienced in keeping blood from passing the glottis and there were no disturbing symptoms either at or after the operation. As was the usual experience, there was no difficulty in swallowing a semi-solid meal a few hours later.

Dr. H. J. DAVIS asked whether there was any passage of food down the larynx after the operation.

Dr. F. H. WESTMACOTT agreed that the result was very good, and the cases were almost exactly similar to one he had in the previous week, and in which there had been no comfort in swallowing for three months. He did the operation under cocaine, and afterwards painted the part with a solution of iodoform benzoine, and ether. That seemed to take away

the soreness, and was based upon the example of Whitehead in excision of the tongue. The operation was done at 11 a.m., and by 3 p.m. the patient swallowed a cup of tea straight off, which he had not been able to do for months. There had been no cough, and no liquid had got into his larynx since the operation. It was now perfectly healed, and the patient was rapidly gaining flesh. Curiously, he could not take milk, as it seemed to clog around the glottis and some went into the larynx, causing coughing for some time afterwards. Koumis was given, and now he could take a glass of milk with comfort.

Dr. WATSON WILLIAMS congratulated Mr. Barwell on his excellent results. He was beginning to feel, however, that greater results could be obtained from rest and sanatorium methods in laryngeal tuberculosis than was formerly suspected, and recently he had had several cases which cleared up in a way he would not at one time have thought possible without operative treatment. He thought care should be taken to differentiate those which could be cleared up without pain and fairly rapidly under sanatoria methods, from those requiring operation. At present the profession was in a tentative position on the matter. He was not surprised that the loss of the epiglottis had not influenced the patient's comfort in deglutition. He would be a little timid in operating on such a case under chloroform, but apparently it could be done if one had at hand means of treatment should blood get into the larynx. In reply to Mr. Waggett, he said the sanatorium-treated cases were not essentially epiglottis cases, but the epiglottis was involved.

Dr. JOBSON HORNE asked Mr. Barwell for further information about the nature of the lesion of the epiglottis. It was so unusual in Dr. Horne's experience of tuberculosis to find the epiglottis typically turban-shaped and no other part of the larynx affected by the disease, that he desired to see a microscopic section cut through the portion of the epiglottis that had been removed. If such a section revealed histological evidence of tubercle, then the case from the standpoint of morbid anatomy was exceptional. From the standpoint of the so-called surgical treatment of laryngeal tuberculosis, it was commonly accepted that the removal of the epiglottis at times afforded relief, and as a palliative measure had been successful. Several similar cases had been recorded in which the physical difficulty produced by disease had been overcome by mechanical means, and not only in tuberculosis; Dr. Furniss Potter¹ had removed the epiglottis as a palliative measure in a case of inoperable malignant disease of the larynx, and with considerable benefit to the patient. One must not, however, regard these palliative measures as remedial, and Dr. Horne agreed with the President that more importance should be attributed to the sanatorium methods as effecting a cure of laryngeal tuberculosis.

Mr. BARWELL, in reply, said the specimen was exhibited in the room with the patient, and Dr. Horne could have a section at any time. The epiglottis was typically turban-shaped, of large size, and ulcerated on the laryngeal surface. Both lungs were affected, and bacilli had been found in the sputum. He believed that of all parts of the larynx the epiglottis was least amenable to treatment by surgery. It was rare to get such a case as the present, where the epiglottis was the only part affected, but in such a case, if removal were done early, the case would do well. The only other case of the kind he knew was Mr. Lake's, in which the epiglottis was the only part markedly affected. It was recorded in the second edition of his book. Indiscriminate operation in tuberculous

¹ *Vide* JOURN. OF LARYNGOL., RHINOL., AND OTOL., vol. xvii, p. 681.

laryngitis was liable to bring it into disrepute; prior to any operation the temperature and general condition should be watched. Where there was dysphagia surgical treatment was best. He had never used general anæsthesia for the purpose; he had done a dozen cases under cocaine, and it was quickly over, and caused little disturbance to the patient. He had never known food enter the larynx afterwards, except once, and then it occurred three months after, and was associated with fixation of the arytenoids in wide abduction.

CASE OF ULCERATION OF EPIGLOTTIS.

Shown by Mr. HAROLD BARWELL. The patient, a man aged forty, came to my Out-Patient Department in July, 1905; he had suffered from hoarseness and slight cough for two years; there was thick yellow expectoration, with, ten days before, a streak of blood. He had been treated elsewhere since February by laryngeal injections of creosote with some improvement. The voice was peculiarly high-pitched; there was no dysphagia whatever. Fauces and nose normal. Larynx, cords slightly reddened, especially the left; left band swollen, arytenoids and interarytenoid region normal, firm pink swelling of the epiglottis with serpiginous ulceration giving rise to a peculiar nodular, worm-eaten appearance. The physician reported "a few dry crepitations at the left apex, nothing active." The length of the history, the freedom from dysphagia, the worm-eaten aspect of the epiglottis, with the absence of massive infiltration, did not appear to me typical of tuberculosis. I gave potassium iodide and the voice much improved and the epiglottis appeared to be cicatrising, but he ceased to attend after four weeks. He reappeared on February 22, 1905; the voice is good, but there had been slight dysphagia for three weeks; there is further destruction of the epiglottis and slight interarytenoid swelling. I should much value the opinion of the Society on the nature of the lesion.

Dr. H. J. DAVIS thought the condition was lupus.

Dr. WATSON WILLIAMS said his feeling was in favour of chronic tubercle.

Dr. WESTMACOTT asked Mr. Barwell what conclusion he drew from the man's copious rash on the back last September, which rash the patient said sometimes came out now. He had also had, for some weeks, profuse nasal discharge. Since three weeks ago there had been pain and dysphagia. The ulceration seemed to be either tubercular or lupoid. There was thickening of the deep cervical glands on each side of the larynx, which seemed to put lupoid condition out of court. He thought it was tubercular, and asked whether tubercle bacilli were found in the sputum or in the scrapings from the epiglottis.

Mr. BARWELL replied that the sputum had not been examined, as the

patient had been in a large out-patient department, and there had been no opportunity, but the physician reported a few dry crepitations at the apex of one lung. He first saw the patient in July, before he had the rash, and the larynx was in almost the same condition as now. He denied syphilis. The iodide of potassium which he was given might account for his rash. He lost sight of the patient for a long time. His own opinion now was that it was lupus. In reply to Mr. Fox as to why tuberculin had not been used, there had not been an opportunity to take the man into hospital.

A. CASE OF ATROPHIC RHINITIS.

Shown by Dr. H. J. DAVIS. Woman, aged 18; atrophic rhinitis; no crusts; posterior wall of naso-pharynx and posterior border of septum plainly visible through each nostril. The naso-pharynx is seen to be moist and lubricated, the oro-pharynx dry and glazed.

Dr. H. J. DAVIS said he really showed the patient more as a curiosity. She came to the hospital complaining of dyspepsia and dryness of the throat. He did not think that he had ever seen a case in which the naso-pharynx was so plainly visible through the anterior nares, nor one in which the posterior border of the septum and the Eustachian tubes were also visible through the nose. He asked why it was that the naso-pharynx was well lubricated and moist and the other part of the pharynx dry. He thought that in atrophic rhinitis there was dryness of the upper part of the naso-pharynx as well as dryness in the lower; but the back of the oro-pharynx in this case had always remained dry and glazed, and nothing that he had done for the patient had brought relief of this symptom of which she complained. He invited opinions as to the cause of the dryness in the oro-pharynx alone, and suggestions with regard to treatment.

Dr. H. SMURTHWAITE said he had a patient at present with atrophic rhinitis, which was certainly as marked. One could see the Eustachian tubes, and towards the frontal sinus, the middle and inferior turbinates, being much atrophied. He complained of the rush of cold air when cycling. He had decided to give him a false turbinal by injecting under the atrophied membrane cold paraffin.

Dr. WATSON WILLIAMS thought it was an open question how far the dryness of the membrane was due to the pathological condition underlying the affection and how far to the simple absence of ordinary moistening of the membrane. He did not think the laryngeal complications were merely due to nasal conditions, but to direct implication of the larynx.

Mr. CHARLES PARKER thought the middle turbinates were much enlarged, and that the dryness was due to the diversion of the air from its usual course through the superior meatus and over the vault of the naso-pharynx. He thought the oro-pharynx would be found dry instead of the naso-pharynx in many cases of marked enlargement of the middle turbinates.

RECENT PHOTOGRAPHS OF SOME CASES OF PARAFFIN INJECTION FOR
NASAL DEFORMITY, AS WELL AS OTHERS TAKEN IMMEDIATELY AFTER
TREATMENT FOUR YEARS AGO.

Shown by Dr. WALKER DOWNIE. The subject of the removal of deformities of the nose by the subcutaneous injection of paraffin was discussed at the last meeting. I learned of this from a member of this Society by letter, but did not know the lines of the discussion until I received my billet yesterday, just as I was leaving Glasgow for London.

All, apparently, are agreed that in many cases a deformed nose can be made more shapely by the judicious and careful introduction of paraffin, and that this can be done with safety.

The point at issue is as to the permanence of that improvement. Some hold that the injected paraffin becomes absorbed, or that it slowly disappears and the deformity recurs, others that it somehow disappears and is replaced by fibrous tissue.

Since receiving the letter referred to I had photographs taken of some of the cases operated upon by me four years ago, and they are shown to-day. If they be examined it will be found—

(1) That the *shape* of the nose is practically identical with the photographs taken within two weeks of the operation, showing that the deformity does not necessarily recur.

(2) In those cases the injected paraffin can be felt as a well-defined firm mass, occupying the same site as it did immediately after injection, and this mass can be readily caught up between the finger and thumb.

I do not believe that the paraffin becomes absorbed—it certainly has not done so in any of my cases, for I have still the majority under observation, and there are two reasons for this belief: (1) The character of this mass when examined with the fingers is the same four years after injection as it was two weeks after operation; (2) from my experience of the removal of paraffin months and years after injection.

In one case where the injection had been given in Manchester, and where the quantity introduced had been excessive, I removed a quantity of the paraffin three years later. In one operated on in London I removed the paraffin two years after operation, and in another operated on in a London hospital I removed paraffin from the forehead six months after the injection. In each case the paraffin was found to be present, and to be in a fine state of division, in small rounded particles, separated by bands of tissue.

The finding of the paraffin in small particles is not to my mind the early stage of absorption, for this division takes place at the time of injection, if molten paraffin be used, as I showed by the experimental injection of paraffin into a mamma one week before its removal. The conditions found on examination afterwards were reported by me at a meeting of the British Medical Association in 1902. In that communication I reported: "In section the paraffin appears almost entirely in the deeper parts of the subcutaneous fat. It is distributed throughout this layer in blocks of varying size, the largest being perhaps about the size of a pea. These masses, which are either distinctly lobulated, or more irregular, with rounded processes, occupy in every case a position between collections of adipose vesicles which are displaced by them. It is inferred that the paraffin has made its way along the lines of connective-tissue trabeculæ between fat-containing cells." And I further expressed this opinion: "From the fact that the infiltration of the paraffin is definite and tolerably intimate it is difficult to believe that its position would subsequently alter to any extent, although its absorption is possible."

The paraffin breaks up on its introduction; it runs along the cellular planes, and is not eaten into later by the living tissues. And it is held in position by the trabeculæ of the minute planes of cellular tissue in the same way as the fat of adipose tissue is kept in place. I must also say that I have never seen migration or wandering of the paraffin after it has once set. Whilst being injected it, of course, follows the line of least resistance, but after it has set I have never seen it wander beyond the confines of the nose.

In those cases where paraffin has been found in other parts of the face I fear it has reached those regions while the injection was being given and while the paraffin was still in a fluid state.

I can understand, however, the wandering of paraffin introduced in the solid state, as this can never become so intimately incorporated with the tissues as when molten paraffin is introduced.

The paraffin which I still employ has a melting point of 106°–108° F. I still use the electric current to heat the needle, as described by me in the *British Medical Journal*, November, 1902, by the use of which I am able to keep the paraffin in a fluid state as it enters and passes through the needle, and by which contrivance the temperature can be so easily regulated that there is no risk of scalding the skin, which some operators fear and others report as having occurred, and I never now employ either a local

or a general anaesthetic. I have now operated upon close on 140 cases, all with very definite deformity, and in most cases with a very satisfactory result, and until I am convinced, by experience, of its futility or danger Dr. Kirschner's theoretical objections, quoted at last meeting by Sir Felix Semon, will not prevent me from giving to those who desire it the benefit to be derived from this operation.

Dr. WATSON WILLIAMS congratulated Dr. Downie on the results he had obtained over a long course of observations in such cases. He was much struck by the really cosmetic results. Some of the cases had been treated four years previously.

Mr. STEPHEN PAGET added his congratulations. He regretted he was not at the last meeting, and had wondered at the dictum then quoted from a German doctor, who said that the paraffin must either remain like a bullet or must vanish. As a fact, the paraffin did not vanish. There were many cases where one wished it would, where it had to be dissected out because it had gone astray. Much of the vague talk on the subject was due either to the fact that operators did not pick and choose their cases, or that they did not pick and choose their paraffin. A case could not be done justice to unless there were loose, healthy skin. It would be a good thing to collect cases years after injection. A few days ago he saw the first case he did three and a half years ago, and the paraffin had not stirred. He then used it of 125° melting point, but now used it at 115°. Most of the misfortunes which occurred were due to having paraffin with a low melting point or to excess of paraffin. It was unfair that a method so useful for bad cases of deformity should have undeserved blame attached to it. No one should use it simply to minister to a person's vanity.

Mr. CHARLES PARKER asked Dr. Walker Downie if, in his experience, injections of cold paraffin were more likely to shift afterwards than those of melted paraffin, and whether there were any dangers connected with its use for increasing the size of the inferior turbinates in cases of atrophic pleuritis. Cold paraffin used by means of Mahu's injector was such a simple method that if there were no dangers attached to it, and if the results were permanent, he would be tempted to employ it.

Dr. SCANES SPICER said the results as shown in the photographs were the best he had seen; one lady had a most beautiful Roman nose. The great objection to the method was the difficulty of carrying it out without scalding and suppuration, in spite of local antiseptic precautions. He had had six or seven cases—all among hospital out-patients—but had not followed them up since they ceased attendance. He would try to ascertain the ultimate result in some of them. In one advanced syphilitic case there was plenty of loose skin on the nose, but the nasal cavities were very foul indeed. The sites of injection suppurred freely and repeatedly, and the patient in the end was no better. He always sealed his cases with a wad of cotton-wool dipped in collodion.

Dr. SMURTHWAITE asked whether the cold paraffin was likely to move after the operation. He produced a beautiful nose the other day by this method, but if it was not going to last more than nine months he would rather not have done it.

Mr. P. DE SANTI said the only two cases he had done were complicated by considerable adhesions, due to necrosed and carious nasal bones. He

found that by a proper subcutaneous dissection of the parts underneath and loosening the tissues the paraffin could be injected satisfactorily. He did not think the adhesions were an insuperable objection to injection.

In reply to questions, Dr. WALKER DOWNIE said that he showed these photographs to prove that the removal of nasal deformities by this method was practically permanent. He agreed with Mr. Stephen Paget that when the skin was loose and healthy the operation was a comparatively easy one and the result satisfactory. When the skin is bound down by adhesions to the underlying bone, then the injection must be preceded by the subcutaneous division of those adhesions, and as soon as the bleeding has been checked by pressure this should be followed by the injection of the paraffin. Dr. Walker Downie had not employed paraffin in the cold state, and so had no experience on which to base an opinion. But he had the feeling that it cannot, injected in this form, become so intimately incorporated with the tissues as paraffin which is inserted while in a molten state. Its shape would, he thought, be readily altered by trifling blows or firm pressure, injuries which would have no effect on the solidified paraffin which had been injected in the molten state. Scalding of the parts spoken of by Mr. Scanes Spicer might readily be prevented by the use of his device of keeping the needle warm by means of the electric current, which is always fully under control and may be regulated at will, and by avoiding the use of paraffins having a melting-point of over 110° F. He thanked the members of the Society for their kind reception of his communication.

DESCRIPTION OF TWO CASES WHERE ŒSOPHAGOTOMY WAS PERFORMED FOR THE REMOVAL OF A DENTURE IMPACTED IN THE GULLET.

Reported by Dr. WALKER DOWNIE. These two operations were performed during the past nine months, and both patients were men, one aged fifty-two and the other thirty-four. In both cases the tooth-plate passed from the mouth into the gullet while the patient was asleep. In both the body was readily caught by the coin-catcher, but in neither case could it be removed. Kilian's œsophagoscope was used in the first case, but it did not reveal the presence of the foreign body, on account, I think, of swelling of the gullet wall, for many attempts to remove the body had been made before he came to the Western Infirmary, Glasgow. The œsophagoscope was not used in the second case, as the patient had emphysema of the neck and immediate operation was imperative.

In the first case the denture had, by pressure, caused necrosis of a small area of the gullet wall.

In each case the incision was made on the left side of the neck in line with the anterior border of the sterno-mastoid muscle, and after removal of the foreign body the gullet wall was not stitched and the wound was lightly packed and allowed to granulate. The

safety of this method cannot be over-estimated. A rubber tube was passed through the nose into the stomach, by which the patient was fed, and this tube was retained in one case for three and in the other for four days.

In each case the wound healed satisfactorily and completely without any complications, and in the second case the man was back to his work as a *chef* on the twentieth day after operation.

SKETCH OF LARYNX AND MICROSCOPIC SECTION OF UVULA FROM CASE OF HYPERPLASTIC CONGENITAL SYPHILIS.

Shown by Dr. A. BROWN KELLY. This was the case of a boy who suffered from stridulous breathing. Examination showed that laryngeal stenosis was caused by immense enlargement of the arytenoids, which formed two smooth, rounded, symmetrical masses. The soft palate and uvula also presented thickening of a similar character.

There was an undoubted history but no signs of congenital syphilis. Specific treatment reduced the infiltrations only slightly, and the sketch of the larynx shown represents its permanent aspect.

The case is one of a small class first described by Sir Felix Semon, and is of interest because of the uniform and symmetrical character of the infiltration, the absence of ulceration, the resistance to specific treatment, and the tendency to acute laryngeal œdema and suffocation.

CASE OF FIBRO-ANGEIOMA OF NASAL SEPTUM.

Shown by Mr. H. BETHAM ROBINSON. The male patient from whom I removed this growth came under my care in March, 1904. He was a robust man, aged fifty-eight, and stated that about the previous Christmas he had knocked his nose with a cane. There seems to have been no inconvenience at the time, but a fortnight after he noticed some fulness of the nose. His only complaint afterwards was progressiveness of the left nostril and epistaxis on two occasions. Examination showed a soft granulomatous-looking growth practically filling all the lower part of the cavity in front and touching the outer wall; behind it reached a short distance between the front of the middle turbinate and septum. Its base of attachment to the septum was half an inch long in an horizontal

direction in front and involving the tuberculum. It was extremely vascular. I removed it with a snare and touched the base with a cautery point. The growth on section had a very fleshy look, "like a sarcoma," but it seemed possibly in the main to be partially organised blood-clot. Histologically, it consists of a very vascular fibrous tissue, the blood-spaces varying considerably in size and some of them containing clot. The margin is more cellular, like granulation-tissue, and at one or two spots there is organising blood-clot to be seen. There has been no recurrence of the tumour.

Dr. PEGLER said the most conspicuous feature of the specimen was the enormous size of its angeiomatous spaces, which were larger than in any other of the seventeen examples in the possession of the Society. The history pointed in favour of a granulomatous character for this growth, and its histological structure was not greatly opposed to it; indeed, a careful study of granulation-tissue in its various forms showed that that tissue foreshadowed almost every variety of bleeding polypus, and, therefore, inclined the speaker more and more to the belief that they were all varieties of granuloma. Dr. Betham Robinson's specimen did not differ essentially from Dr. Kelson's exhibited to-day. The plasma layer replaced the squamous epithelium almost completely, the granulation-tissue zone was least conspicuous, and the central body of fibrous and fibro-angeiomatous tissue predominated.

A PATIENT SHOWN IN JUNE, 1905, WITH THICKENING OF RIGHT CORD,
THOUGHT TO BE MALIGNANT; EXHIBITED AGAIN FOR FURTHER
DIAGNOSIS.

Shown by Dr. SMURTHWAITE. The patient is a man aged fifty-eight, whom I brought before the Society in June of last year, suffering from a progressive loss of voice and cough of two years' duration. When he first consulted me the following was the laryngeal condition: The right cord was uniformly thickened, and at the junction of its posterior and middle thirds there was a small growth about the size of a pea. In addition the false cord was diffusely infiltrated, or rather had the appearance of a general thickening and irregularity of the membrane. There was no fixation of the joint, but the cords could not be properly approximated on account of the small growth above mentioned. There was general redness in the interior of the larynx.

I removed the growth and submitted the same to a pathologist, who pronounced it to be a squamous epithelioma. Some three weeks later the patient was shown to the members of the Society, and some half-dozen kindly examined him, and later expressed

the opinion that the laryngeal trouble was undoubtedly malignant, and advised that a laryngo-fissure be undertaken and the growth be thoroughly removed. This procedure I determined to carry out, but the patient's voice and the general appearance of the larynx improved so much that I put off and have not felt justified in carrying out a more or less radical operation.

The patient is here again to-day, some nine months later, and I should be very glad if those same members would again examine him and say if they still hold to the diagnosis.

Mr. DE SANTI said he was one of those who examined the case a year ago, and then the appearance was such that he thought it malignant. There was now no sign whatever of malignancy.

Dr. STCLAIR THOMSON said he was another of those who were mistaken over this case, but he did so in good company, because one of those who were strongest in regarding it as malignant was Sir Felix Semon. He admitted there was no fixation of the vocal cord. But this case raised the question whether possibly vocal cords had sometimes been removed under the impression that they were malignant, when perhaps they were not so. Dr. Smurthwaite had the report of a trustworthy pathologist in the north that the growth was malignant; this was confirmed clinically by members of the Society; and if the case had been operated on it would have been recorded as a case of cure of malignant disease of the larynx. The Morbid Growths Committee of the Society reported that it was not malignant, and the whole condition seemed to be clearing up. It made even members of the Laryngological Society of London a little humble.

Mr. WAGGETT said this case could not be quoted as one telling against the value of histological pathology, for the Morbid Growths Committee, on examining the specimen, which had been previously reported upon elsewhere, had no hesitation in saying that they could see nothing in the least suggestive of malignant disease.

Dr. PEGLER said that two or three years ago a case was exciting interest, and was reported upon as papilloma, but further investigation led to the belief that it might be regarded as a carcinomatous condition. The pathologist regarded it as papilloma. It showed how careful one should be in reporting. In Dr. Smurthwaite's case the Morbid Growths Committee only reported that it was not any malignant disease of epithelium.

Dr. WATSON WILLIAMS expressed the Society's indebtedness to Dr. Smurthwaite for bringing the case forward again.

Dr. SMURTHWAITE, in reply, said that two weeks before bringing the case up he had naturally made a big wound on the right cord in removing the growth, and there was much inflammatory thickening round the base. Thus it showed an ulcer, and knowing of the report of the pathologist that it was squamous epithelioma, members would incline to that diagnosis. Had they seen the larynx before the small growth was removed their opinion might have been different. When the man was first brought to him he gave a guarded diagnosis, saying that the thickening of the false cord and the growth gave a suspicion of malignancy, but a point against that was the small amount of fixation of the cord. The chief symptom was coughing, which had existed two years, but since the removal of the growth had entirely disappeared, and the patient was now perfectly well.

CASE OF SECONDARY SYPHILITIC LESIONS OF THE VOCAL CORDS IN A
GIRL AGED TWENTY.

Shown by Dr. PEGLER. The patient contracted syphilis in a northern town about a week before Christmas, 1905, and had only been under observation for ten days. She had abundance of rash on the body and legs, and mucous patches on the enlarged tonsils and pharyngeal wall. She had consulted Dr. Pegler on account of hoarseness and dysphonia. The vocal cords were red, and showed yellowish patches of ulceration; their borders were eroded, all more marked on the right. There seemed good reason to believe that the condition represented a phase of mucous patches on the cords.

A BOY, AGED SEVENTEEN, WITH ABSENCE OF RIGHT CHOANA.

Shown by Mr. WAGGETT.

Dr. STCLAIR THOMSON thought such cases worthy of some attention, as they showed a certain fallacy in accepting experimental results from the physiological laboratory. The experiment of Ziem relating to the nasal cavities of puppies was, perhaps, the most quoted of any experiment in the literature of laryngology—*i. e.* that sewing up one side of the nose prevented that side of the face from developing. He (Dr. Thomson) could bring forward a young woman, aged nineteen, with a most symmetrical face and an excellent low Norman arch to her palate; but the mother said she had only been able to nurse her, as an infant, at one breast, because on putting her on the other side the only open nostril seemed to block up. This patient always had to wait for the mucus to trickle out of one nostril, and then wipe it away. That case confirmed Mr. Waggett's point, *i. e.*, that there was perfect symmetry between one side and the other, and both those cases from Nature were opposed to Ziem's experiment. He operated upon his case, and she had a half-membranous, half-bony obstruction, quite complete, as he was able to feel in the post-nasal space. He broke it through and nipped a good piece out of the vomer; he had examined the case ten months later, and there was no recurrence.

Dr. H. J. DAVIS said that in the experiment with the puppy mentioned by Dr. StClair Thomson, in which the nostril had been obliterated, the obstruction would in this case be in the anterior part of the nose, but in Mr. Waggett's case the nose was obstructed a long way back, and this might probably account for the different results.

Dr. SCANES SPICER thought the Society should feel indebted to Mr. Waggett for bringing this case forward. It was one of the most interesting the Society had ever had, for it afforded the opportunity of testing the interdependence of arrested functional activity and growth. He had not yet satisfied himself that it was a case of congenital bony occlusion, for he had not been able to see very well, or to interpret the masses which he had dimly seen. He thought he saw a small foramen just below the superior fornix on the right side, as if that choana

were not occluded completely by bone. Several points suggested that the face here was not symmetrical. There was alternating internal strabismus, not infrequently seen in cases of nasal obstruction, and which one sometimes found to disappear entirely after clearing the obstruction. He believed also that the eyes would be found to be astigmatic. The patient's palate was very high. Dr. StClair Thomson's case of posterior occlusion was a different matter from getting obstruction in the front of the nose. Zeim's experiments were done with the nasal channels blocked anteriorly or throughout, and other factors than the obstruction assisted in the results he got, such as the muscular activity of alæ and the inflammation which had occurred. The case was deserving of full examination and consideration, even to the extent of devoting a whole evening to it, and most members would no doubt look up previous work bearing on the subject.

Dr. WATSON WILLIAMS thought it would be well to ask Mr. Waggett to bring the case again to the next meeting, and he could defer his reply till then.

CASE OF SWELLING PROJECTING FROM LEFT TONSIL (RETENTION CYST)
IN A GIRL AGED TWENTY-THREE.

Shown by Dr. FURNISS POTTER. No symptoms were complained of. A swelling was to be seen protruding from the left tonsil about the size of a horse-bean. The surface was of a pale yellowish grey colour, and examination with a probe gave the impression of fluid. Two similar conditions were observed on the right tonsil, but much smaller in size. The diagnosis was confirmed by incision of one of these latter, which resulted in the extrusion of a small quantity of tenacious secretion and collapse of the swelling.

MICROSCOPIC SECTION FROM A CASE OF NASAL ANGEIOMA (BLEEDING
POLYPUS) REMOVED FROM THE FLOOR OF THE INFERIOR MEATUS
IN A GIRL AGED FIFTEEN, BY Dr. KELSON.

Shown by Dr. PEGLER. The patient was shown by Dr. W. H. Kelson in March, 1903, but there was some error in the report of the case, which was confused with the preceding one. No section was exhibited. This slide had been kindly handed over to the Society by Dr. Kelson. It displayed very clearly the three zones so commonly seen in discrete nasal angioma where the stratified epithelium has disappeared—viz. (1) a plasmatic layer; (2) a granulomatous or lymphocytic zone; (3) a trabecular fibro-angiomatous meshwork constituting the body of the growth in which the endothelioid cells come into prominence and the lymphocytes diminish. Though growing from the floor of the nose, this specimen was almost identical in character with that shown by Dr.

Scanes Spicer in December, 1897, removed from the triangular cartilage, showing how little value attached to a grouping of these bodies based upon site of growth apart from pathology.

A WOMAN WITH IMMOBILE RIGHT VOCAL CORD ; PREVIOUSLY SHOWN
MAY 5, 1905.

Shown by Mr. DE SANTI. The patient was brought before the Society after the lapse of ten months to show that the condition of the larynx was unaltered. When exhibited in May, 1905, considerable diversity of opinion was expressed as to the diagnosis. Dr. Scanes Spicer had suggested aneurysm, but a radiograph showed nothing abnormal. Sir Felix Semon had been doubtful as to the question of paralysis or mechanical fixation, and had suggested possible congenital ankylosis of right crico-arytenoid joint. Dr. Dundas Grant had suggested epithelioma, and Dr. Horne a tubercular origin. Mr. Barwell considered the condition to be one of fixation.

Since May the patient had been under iodide of potassium, and had lost all cough, hoarseness, and pain, and expressed herself as being in much better health generally. The condition of the larynx was, however, exactly the same as when first seen. Mr. de Santi considered the case one of mechanical fixation; whether of congenital, specific, or rheumatic origin it was difficult to say.

Mr. WAGGETT thought it was a case of articular fixation, and not paralysis, and Dr. DAVIS agreed.

Dr. WATSON WILLIAMS said he took the same view as Mr. Waggett from the position of the fixed arytenoid, which was suggestive of some implication of the joint.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND FIFTH ORDINARY MEETING, *April 6, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B.
W. JOBSON HORNE, M.D. } Secretaries.

Present—26 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The ballot was taken for E. TAIT ROBINSON, M.D., M.Ch., R.U.I., who was elected a Member of the Society.

The following communications were made :

A CASE OF SUDDEN LOSS OF VOICE.

Shown by Dr. H. J. DAVIS. The patient, a man aged forty-three, had had sudden loss of voice fourteen days previously, following "a cold"; the cords were subacutely congested, the left cord was fixed. The case was shown for diagnosis.

Dr. Davis said he thought the man had had his cord fixed for some time, and on this had supervened an attack of acute or subacute laryngitis. It was probably a coincidence. He did not know of any disease which would produce fixation on one side completely in a fortnight. There seemed to have been no loss of voice previously. The chest showed no signs of aneurysm or tubercle, though the patient said he was getting thinner. He had been in the Army in India. There was scarcely any sputum to examine for bacilli.

Mr. CRESSWELL BABER said there was a good deal of swelling of the left ventricular band as well as want of movement in that cord. He could not say what the nature of the case was. It might be either syphilitic or tubercular.

Mr. ATWOOD THORNE pointed out that the patient gave a history of fracture of the base of the skull two years ago.

Dr. DUNDAS GRANT thought the case was well described as fixation of the left cord rather than paralysis. He believed the fixation was due to a mechanical local process. Like other speakers, he did not think the fixation was likely to have come on in the short time specified in any other form than as an acute arthritis of the joint, which would almost certainly have been accompanied by pain. It was very probably due to old specific trouble, and the present sudden loss of voice was attributable to laryngitis following a "cold."

Dr. STCLAIR THOMSON thought the diagnosis could be narrowed down to specific disease or tubercle. The man stated that he had lost two stones in weight, which was a considerable reduction. He (Dr. Thomson) had a suspicion that there was something like ulceration. He agreed as to its being fixation and not paralysis, and that there was diffuse infiltration about the cord. The situation was towards the arytenoids.

The PRESIDENT said the general pallor in the larynx, which was described as "subacutely congested," struck him as supporting the view that the condition was tubercular, especially when taken with the great loss of voice. There was a fair approximation of the cords.

Dr. DAVIS, in reply, said that if the paralysis of the cord on the left side had only come on during the last fortnight coincidently with the laryngitis, there would have been more paresis in the other cord. His opinion was that he had had trouble there for some time. He was still able to talk. The acute laryngitis probably called attention to a condition which had existed for some time.

A CASE OF NASAL OBSTRUCTION.

Shown by Dr. DAVIS. The patient, a man aged sixty-two, complained of nasal obstruction of fourteen weeks' duration on the right side following facial paralysis; the asymmetry in the apertures of the nostrils was still marked. Under the electrical treatment the condition was improving.

Mr. CRESSWELL BABER drew attention to the deflection of the septum; the anterior edge of the cartilaginous septum projected into the right vestibule and helped to produce the obstruction.

Dr. WILLIAM HILL said in his experience such a condition sometimes caused annoyance after facial paralysis in connection with aural disease. A week or two ago he had a patient who had had facial paralysis, but in whom a good deal of movement had returned; he did not worry whether he could quite close his eye, but wanted to breathe through his left nostril. He was recently having electricity twice a day, ten minutes at a sitting; but that did not answer, therefore he put in a celluloid plug, and that cleared up the disability at once. The patient was very much relieved, both in mind and in regard to respiration.

A CASE OF ABSENCE OF THE RIGHT CHOANA.

(Shown at the previous meeting, March 2, 1906.)

Shown by Mr. E. B. WAGGETT. The patient, a boy aged seventeen, had had symptoms, pointing to the absence of the right

choana, dating from infancy. The face was symmetrically developed.

Dr. WILLIAM HILL said he was not sure whether the reference to absence of the right choana was not a terminological inexactness, because he found the patient had got an anterior naris. He believed that in rhinological literature the term "choana" was applied to the whole cavity of the posterior and anterior nares.

Mr. CRESSWELL BABER, in answer to Dr. Hill, said that the term "choana" applied to the posterior aperture of the nasal cavity.

Dr. DONELAN said he had referred to a Greek dictionary, which said that "choana" was equivalent to the Latin "infundibulum." A man who was a great drinker in ancient Greece was called a choana. The term referred to the funnel-shaped space leading to the cesophagus. It was quite incorrect to speak of "posterior choana," though usage allowed "posterior nares."

Dr. SCANES SPICER said Dr. Donelan's rendering of the meaning of the word "choana" was doubtless correct, but in the conventional use of the term in rhinology it signified the opening of the posterior nares.

Mr. WAGGETT explained that he brought the case because he thought the condition rare. The boy had never had any breathing space through his right nose, which was quite normal and well developed, except that there was no posterior orifice, the choana being blocked by a bony wall. There seemed to be almost perfect symmetry of the face, and the palate was not very ill formed, for the reason, he took it, that breathing had been very adequately conducted through the left nose, which was large. The boy had not suffered from the effects of nasal obstruction. He was aware that there were adenoids and catarrh present. Three months ago he came with subacute otitis media on both sides.

Dr. DUNDAS GRANT reminded members that he once brought forward a case (December 13, 1893) with obstruction of one posterior choana and with asymmetry of the face, but the atrophy was on the opposite side to the obstruction. Shortly afterwards Mr. Baber showed a similar case.

Dr. H. PEGLER asked whether the cases shown by Dr. Grant and Mr. Baber some time ago were not cases of web-like formations.

Dr. GRANT replied that in his case there was a web-like formation, but the obstruction was complete.

Mr. CRESSWELL BABER, in reply to Dr. Pegler, said he showed his case in 1893. The patient was a boy aged six, and his right choana was completely obstructed, the obstruction being partly membranous and partly bony. The right cheek, the affected side, was more prominent than the left.

Dr. LAMBERT LACK said that the great interest of this case was that the teeth were equally irregular on both sides, the palate was high equally on both sides, and the face was as symmetrical as that of most people, although the nasal obstruction was entirely unilateral. These facts had an important bearing on the etiology of these deformities of the palate and teeth. If, as he maintained, the deformity was the direct result of the increased tension of the soft tissues of the cheeks, which in turn resulted from keeping the mouth open, it did not matter which side of the nose was blocked provided that the nasal passages were insufficient and the patient was compelled to keep the mouth open. The effect of the open mouth was then bound to be symmetrical deformity, as in a case

which he had shown at that Society the patient had one side of his face paralysed for many years. In this case the deformity was unilateral, because the paralysed side of the cheek was flaccid, and consequently could exert no increased pressure. These two cases taken together were the strongest proofs in favour of the theories which he (the speaker) had always supported.

Dr. SCANES SPICER said it was important to decide the fact whether there was facial asymmetry or not. Last time he saw the case he thought there was not, but subsequent inspection under different illumination led him to think there was. There was a noted Cambridge school of anthropology, and Mr. Waggett would be doing the Society a service if he would have careful anthropometric measurements made. He judged the left side of the face to be decidedly broader than the right. No one dreamed that nasal respiration was the only factor in bringing about the evolution of the face. Ziem, in his elaborate monograph (*'Monats. für Ohrenheilk.,'* Berlin, 1883) mentioned many other momenta; and nasal obstruction on one side would not of itself cause such an enormous difference in the two sides of the face that accurate measurements were superfluous. But assuming the patient's face was symmetrical, each time he had examined the boy he found the left side blocked as much as the right, practically a bilateral stenosis. The same thing had been noticed in Zaufal's case (quoted by Ziem in his monograph), that of a girl aged seventeen, who had bony obstruction on one side and catarrhal obstruction on the other, so that the nose was practically entirely blocked. The eyes also should be examined, as he believed there would be found a considerable difference in the shape of the eyeballs on the two sides and astigmatism. There seemed also to be too much sclerotic showing. In many ways the lad's physiognomy was unusual and peculiar.

The PRESIDENT said some years ago he had a couple of cases of unilateral and one of bilateral congenital atresia of the choanæ, and in the unilateral cases certainly there was no asymmetry. Both were relieved by operation. In those cases on which he had operated he noticed that whereas the two bony margins of the aperture were in close apposition, there was a little membranous material between the two. That was also the case in the patient shown by Mr. Cresswell Baber. He doubted whether there was any real bony fusion between the two sides; there was usually a little aperture which could be got through. He understood the boy had adenoids, so that they should be taken into consideration in accounting for the appearance of the face.

Dr. LOGAN TURNER thought the remarks which had been made suggested that the examination as to asymmetry should not be limited to the face but should include the limbs. The *'Edinburgh Medical Journal'* of last November contained the record of a very interesting case in which there was asymmetry.

Dr. PEGLER asked whether Mr. Waggett proposed to do anything to open up the atresia.

Dr. H. J. DAVIS agreed with Dr. Scanes Spicer as to the presence of asymmetry in the boy's face. If he were set to draw the face he would make it wider on the left side.

Mr. WAGGETT, in reply, said he had been seeing the boy about three months, during the early part of which he could breathe perfectly through his nose. His adenoids were now becoming troublesome and must be dealt with. He did not yet know whether he would operate upon the nose. There might possibly be slight want of symmetry in the face, but

not more than was seen in a large proportion of normal persons. Some people thought that the development of the facial sinuses was dependent upon the function of respiration. But in this boy the antrum was very well developed, although connected with a nose which had nothing to do with respiration. The speaker could not help looking upon the tongue as the prime factor in determining the formation of the mouth. It was the principal muscular organ of mastication, and with the subsidiary muscles (*e. g.* masseters) moulded the facial skeleton. The plastic influence of that remarkably powerful muscular action was at play throughout the twenty-four hours, under normal circumstances, and where mouth-breathing existed the tongue could no longer mould the palate, and as a consequence the alveolar arch developed no proper lateral expansion, and the narrow (so-called "high-arched") palate resulted. In this boy, thanks to his thoroughly adequate left nose, nasal breathing had been largely practised and the tongue had moulded the palate into very fair form. The palate was symmetrical.

A CASE OF ULCERATION OF THE LEFT CORD.

Dr. KELSON showed a man aged twenty-six suffering from ulceration of the left vocal cord. Patient had been hoarse for three months; he had not lost weight, and no lung changes had been detected, but there was a family history of phthisis. The sputa were very scanty and had not been examined. There was no history of syphilis. The posterior half of the left cord was ulcerated, but it moved well; the right appeared to be normal. No enlarged glands could be felt.

Dr. DUNDAS GRANT thought the case was tuberculous.

Dr. SCANES SPICER thought the case had the red, angry look of a specific ulceration. Moreover it was unilateral.

The PRESIDENT asked whether any remedies had been tried.

Dr. KELSON, in reply, said iodide of potassium had been given for two months, and the case appeared now to be exactly where it was before.

Dr. H. J. DAVIS said if the case was tubercular iodide of potassium given for two months would have made the condition worse.

INSTRUMENTS FOR SUBMUCOUS RESECTION OPERATION.

Shown by Dr. H. SMURTHWAITE. In rectifying septal deflections by means of the submucous resection operation our two greatest difficulties are (1) the commencing separation of the muco-perichondrium, (2) the cutting through the cartilage previous to separating it from the muco-perichondrium of the opposite side. Within the last two years a number of ingenious instruments have been devised by men working in this field of surgery which have materially helped to simplify and lessen the time of operation. The use of a certain instrument is often a matter of adaptation,

one man being able to do good work with one instrument, whilst another prefers some other shape. With one or two exceptions, such as Killian's plough and Hajek's chisel, I have had the instruments I use for the operation made for me by Mayer and Meltzer to my own design. Two which I have had made for me just recently were designed for overcoming the before-mentioned difficulties. One is a rougine for separating the membrane after making the preliminary vertical incision. I used to find some difficulty in getting properly underneath the perichondrium with the straight smooth-edged elevator, sometimes merely separating the mucous portion of the muco-perichondrium, with a consequent rupture of the same when any force was applied. With this rougine, having a curve, the force can be more readily applied on to the septum and the fibrous portion of the membrane raised. After the part is once raised from the cartilage the curved separator can be used to complete the separation of the membrane. The other instrument I have is a knife for cutting through the cartilage. Its cutting edge is in a line continuous with the long axis of the handle. The instrument can thus be used like a pen, and lends itself to that delicacy of movement so necessary when cutting through the cartilage, desirous as we are of not wounding the opposite muco-perichondrium. The cartilage is cut through obliquely till the blade disappears up to the guard on the handle, the resector is then introduced, and the separation of the necessary amount of cartilage completed.

A CASE OF GLOTTIC STENOSIS.

Shown by Dr. STCLAIR THOMSON. A girl, aged sixteen, with laryngeal stenosis. This case was shown for diagnosis, which rested between functional adductor spasm and bilateral paralysis. It was difficult to apply the usual tests for making her inspire suddenly and deeply, as she was a foreigner, speaking only Russian and Yiddish. It appeared she had been some months in a Russian hospital for the same affection. He was inclined to view the case as one of functional spasm. There was a constant twitching movement of the arytenoids, although the cords did not abduct. When taken into the hospital and watched, the girl slept quietly, and only developed stridor when attention was given her.

Dr. SCANES SPICER thought the case was one of functional tonic adductor spasm, with clonic spasms superadded.

Mr. ATWOOD THORNE said that when he saw the patient she was very

tired, and the right side of the larynx was absolutely fixed. The left side moved a little.

Dr. DUNDAS GRANT wondered whether Dr. Atwood Thorne was certain as to the side, because he (Dr. Grant) found the left side almost immovable, while the right had some movement. Possibly Dr. Thorne and he took different fixed points. He regarded it as an hysterical case. Anæsthesia of the pharynx seemed to be indicated by her extraordinary tolerance of examination. She also had considerable exaggeration of the knee-jerks.

Dr. FITZGERALD POWELL thought the case should be regarded as one of abductor paresis, not total paralysis, as there was evidently some movement in the left cord. He was inclined to think that the condition was due rather to the toxin of diphtheria than to hysteria or the neurotic element. The mother had stated that the girl had been in hospital in Russia one year ago, and that the doctor had told her that her daughter was suffering from diphtheria.

Mr. DE SANTI thought the present case of adductor spasm was very much like one he showed some time ago, and which some members mistook for double abductor paralysis. One member got her to make a prolonged "e," and she then took a deep breath and the cords abducted thoroughly. The nature of the case was eventually settled by putting her under an anæsthetic; her breathing had been so bad that his colleague, Dr. Hall, thought tracheotomy would be necessary. But under the anæsthetic the breathing became perfect. He thought the present patient should be put under an anæsthetic, when he believed she would breathe all right.

Dr. SMURTHWAITE said the patient gave a history of it having come on all at once, and that was in favour of hysteria. The cords did not come into line, there being a gap of crescentic shape between them.

Dr. STCLAIR THOMSON, in reply, said one cord seemed to be moving better than the other, which he believed to be against the view that it was functional. But still, he thought it was functional, because when she came to his throat-room she developed a good deal of stridor as she approached his chair. She was in the ward a week, and was carefully watched there at night, when there was no stridor whatever. He had never been able to get her to dilate her cords.

SPECIMENS AND DRAWINGS ILLUSTRATING VARIOUS PATHOLOGICAL CONDITIONS OF THE NOSE AND THROAT.

Shown by Dr. LOGAN TURNER.

(1) *Larynx of a boy from a case of sudden death.*—The specimen shows a large papilloma attached to the left vocal cord. Almost the whole lumen of the larynx above the level of the glottic chink was filled up by the tumour. The boy, aged ten, had always enjoyed good health, and had never required medical advice. His mother stated that she had occasionally noticed a slight hoarseness of voice, but it was never sufficiently marked to call for special advice. He had never been troubled with shortness of breath or any choking sensations, and he had been able to run about and

play with other boys. He died suddenly while eating his dinner without any premonitory symptoms. He appeared to choke. Professor Harvey Littlejohn, who performed the *post-mortem* examination, very kindly handed over the specimen of the larynx to me. When the larynx was removed, the appearance presented by its upper aperture suggested its occlusion by a piece of meat. After washing the parts, and thus removing all the secretion, the upper aperture of the larynx was found to be almost completely occluded by a papillomatous tumour. When the larynx was divided and its interior examined, the papilloma was found to be attached to the left vocal cord.

The case is one of great interest, not only clinically, but also from a medico-legal aspect. It is difficult to realise how the child had remained free from any symptom calling for medical advice.

Keratosi of the larynx.—The patient, A. R——, aged sixty-four, who followed the occupation of green keeper upon a golf course, was admitted to hospital complaining of hoarseness and some pain in the throat. He had been engaged in this outdoor occupation for ten years, previous to which he had worked as a miner in the coal-pits for thirty-five years. He had been subject to asthma for the last twenty years, two of his sisters being similarly affected. His present occupation exposes him to every kind of weather.

About twelve months before his admission he caught a severe cold; since then he has been constantly hoarse. During the last three months he has complained of occasional pain in the region of the larynx. He is also troubled a good deal with cough and some expectoration.

Examination of the nose, fauces, and pharynx showed no abnormal condition. On laryngoscopic examination, however, a very unusual appearance was observed. The upper surface of the right vocal cord throughout its entire length presented an irregular, mammillary appearance, the free edge of the cord having an irregular outline. Posteriorly this appearance was not confined to the true, but passed without any delimitation on to the upper surface of the false cord. The anterior two thirds of the left vocal cord showed an exactly similar appearance, but here the condition was limited, the false cord being unaltered and the posterior third of the true cord showing no alteration from the normal. The affected areas were of a greenish white colour. On closer inspection, the impression conveyed was that the affected parts were covered by a firm membrane made up of a number of small pinpoint excrescences projecting above the surface of the surrounding

mucous membrane, not unlike a number of small stalagmites, which could not, however, be separately differentiated the one from the other. Dr. McBride, who saw the case with me, expressed the opinion that it was probably one of keratosis of the larynx. This view was confirmed by microscopic examination; under cocaine anæsthesia I removed with forceps a portion of the membrane, which was firm in consistence and fairly adherent to the underlying parts.

An examination of the tissue removed was kindly made for me by Dr. T. Shennan. The pathological condition is well shown in the microscopic sections. The excrescences are made up of numerous layers of cornified epithelial cells. Upon the free surface the most superficial layer is becoming broken up into a number of small detached and semi-detached fragments, portions of which have become shed, forming *débris*. Some of the deeper cornified layers, again, present a teased-out appearance. Towards the base of the excrescence the stratified appearance becomes lost and a thick layer of epithelial cells is visible. Unfortunately, none of the sub-epithelial tissue had been removed in the forceps, so that its histological appearances are unknown. Here and there upon the surface clumps of branching mycelia are seen, evidently some form of leptothrix.

(3) *Pachydermia of the larynx*.—The patient was a married woman aged twenty-five. She was very well nourished and had always enjoyed good health. She had had two children. The family history was good, there being no lung trouble. Four years before first coming under observation she began to be troubled with hoarseness, which had continued more or less constantly since that time. The patient had no expectoration, and examination of the chest revealed no evidence of pulmonary disease.

Nothing abnormal was observed in the nose, naso-pharynx, or pharynx. On laryngoscopic examination the interarytenoid space was seen to be occupied by a greyish-white infiltration, the heaping up being greater in the mesial plane. The surface presented a slightly uneven appearance, but there was an absence of any mesial furrow. The posterior third of the right vocal cord had a ragged, eaten-out appearance, suggestive of a tuberculous ulceration. The left vocal cord was perfectly normal. The long duration of the symptoms and the absence of any evidence of tubercle in the lungs favoured the diagnosis of pachydermia.

(4) *Diffuse papilloma of the larynx*.—A woman, aged forty-four, had suffered from hoarseness for eight years, with gradually

increasing difficulty in breathing. Since childhood she appears to have had frequently attacks of hoarseness, but these were associated with colds, and the voice was not permanently impaired until eight years ago. She had never had the larynx examined until the autumn of 1905. She has occasionally coughed up small pieces of "flesh," but no bleeding occurred at these times. Difficulty in breathing has been increasing lately. Her general health is good. Her father died of phthisis.

When the larynx was first examined the anatomical structures beneath the upper aperture were not recognisable; both false cords, the true cords, and the posterior surface of the epiglottis presented a mass of papillomatous-like tissue, the lumen of the cavity being very much diminished.

The whole of the tumour, with the exception of one or two fragments, has been removed, piece by piece, by endolaryngeal operations. The microscope has revealed nothing but simple papilloma structure.

(5) *Fibroma of the larynx*.—The patient, a male, aged thirty-three, had complained of slight hoarseness for several months. Laryngoscopic examination revealed the presence of a small, pink tumour attached to the free edge of the left vocal cord at the junction of its anterior and middle thirds. The tumour was somewhat pear-shaped, with its long axis lying in the antero-posterior diameter of the glottic chink, the larger end of the growth being anterior. It was attached to the vocal cord by a short pedicle situated about the centre of the tumour. On phonation it became tilted on to the upper surface of the left cord, thus allowing the two cords to approximate, a circumstance which accounted for the small amount of hoarseness of voice which was present.

(6) *A case of lobulated, encapsuled tumour attached to the posterior wall of the naso-pharynx which presented the clinical features of a simple tumour, but which microscopically proved to be a sarcoma*.—A male, aged fifty, a house painter, had always enjoyed good health. He presented himself for examination because a friend of his had recently undergone an operation for malignant disease of the throat. He gave the following history: Two years previously he had suffered from a severe cold accompanied by pain in the throat. While examining his own throat he noticed a swelling of some size, which at the end of about a fortnight burst and discharged a white, tough material which the patient says he was able to remove by means of a fork. Healing took place, but some swelling has persisted since that time. It has given him no trouble

for the last two years, but for the reason stated above he sought medical advice. Examination of the pharynx revealed nothing abnormal, the soft palate presenting a normal appearance and not bulged forwards. By a peculiar movement, evidently acquired by practice, the patient was able to draw his soft palate upwards, so that he could then bring into view when the mouth was opened a tumour which projected downwards and forwards beneath the elevated palate. The mass which thus became visible was of firm consistence, circumscribed, but freely movable upon the posterior wall of the naso-pharynx to which it was attached. It was encapsuled and lobulated, four small lobules making up the main mass of the tumour. There was no ulceration of the surface, but a few small distended veins were visible upon its surface. There was no pain on pressure. There were no enlarged cervical glands. There was evidently no attachment to the periosteum of the vertebræ or basis cranii, the mucous membrane of the posterior naso-pharyngeal wall being the seat of attachment.

The tumour was easily dissected out under local anæsthesia, an incision being made round its base of attachment. It had no deep attachments. The base of the tumour measured two inches in circumference. One year after the operation the patient was in excellent health—merely a smooth cicatrix was visible and there were no enlarged cervical glands.

The microscope shows that the tumour is made up of sarcoma-cells of the round-celled variety. The tumour has a dense fibrous capsule.

(7) *Ulceration and destruction of the soft palate and posterior pharyngeal wall.*—The patient was a woman aged thirty-seven, the subject of acquired syphilis.

(8) *A dense fibrous tissue diaphragm completely shutting off the pharynx from the naso-pharynx with the exception of a small, circular aperture placed mesially, which admitted the point of a surgical probe.*—The patient was a young woman aged twenty, the subject of hereditary syphilis. It was found on operation for removal of the diaphragm that both choanæ were completely obstructed by dense fibrous tissue.

(9) *Large cyst of the right ventricular band.*—The patient was a labourer, aged forty-seven, who had first noticed slight hoarseness two years before he came under examination. This at first tended to become worse, but during the last eighteen months the voice has remained much the same, being characterised by a moderate degree of hoarseness. During the last three or four months he

has had difficulty in swallowing water, a choking sensation being produced during the act. Solid food was swallowed with ease. Lately during exertion he has had some difficulty in breathing, but not when at rest or when lying in bed—otherwise he enjoys good health.

Laryngoscopy showed the interior of the larynx almost completely filled up by a large, smooth, spherical swelling occupying the position of the right ventricular band, and concealing from view both true cords and a portion of the left false cord. The swelling extended outwards and involved the right ary-epiglottic fold, passing even beyond that, while anteriorly it passed on to the posterior aspect of the epiglottis. It presented a tense appearance, the vessels upon its surface being dilated, and giving the impression that there was fluid within the swelling.

Under cocaine the tumour was incised with Heryng's knife; it immediately collapsed, a quantity of clear, gelatinous-like material being extruded and spat up. Some thickening of the right ventricular band remained for a considerable time, but at the end of a year all trace of the cyst had disappeared.

Dr. PEGLER said, in reference to the case of keratosis of the larynx, it had just been stated that there were only four recorded cases of that condition. He believed, however, that the case of the patient with white accumulated excrescences on the vocal cords, shown by Dr. Scanes Spicer at the last meeting, was one of keratosis of the cords due to *leptothrix buccalis* or mycosis. It corresponded, as suggested by Sir Felix Semon at the time, closely in appearance to this drawing of Dr. Logan Turner's case. He (Dr. Turner) had kindly consented to send a microscopical specimen to the Society so that the sections of the two cases could be compared.

WOMAN AGED FIFTY WITH MALIGNANT GROWTH IN NASO-PHARYNX; QUESTION OF OPERATION.

Shown by Mr. DE SANTI. This patient has a large cauliflower-like growth in the naso-pharynx, growing downwards so as to be visible in part below the level of the palate. It is hard to the touch and extensive in its attachments. There are deep-seated glands in the neck. She has had sore throat since the summer, but until lately has not consulted any medical man. She is brought before the Society for an expression of opinion about operation. Mr. de Santi considered the condition to be too extensive for operation.

Mr. CRESSWELL BABER asked whether the patient had been given iodide of potassium.

The PRESIDENT thought it seemed too deep for operation. There was tenderness over the glands, but he could not say whether they were infected.

Dr. LOGAN TURNER recommended putting the patient upon iodide of potassium if that had not been done. There was an absence of the characteristic cervical glandular enlargement such as one would have expected with malignant disease.

Mr. DE SANTI, in reply, said the patient had not been given iodide of potassium; he only saw the patient a few days ago. He would do so, although he considered that no benefit would accrue. There were deep-seated glands to be felt in the neck.

. CARCINOMA OF THE NASO-PHARYNX.

Shown by Mr. CHARTERS SYMONDS. Mr. T—, aged fifty-five, was brought to me for a gland in the right side of the neck and for some deafness and obstruction of the right nostril. There was found projecting a rounded swelling, quite easily seen, concealing the right Eustachian tube and obstructing the nostril on the right side. The lump was smooth in outline, firmly attached to the pharynx; the surface appeared to be unbroken, but it had bled a little on handling. There was one principal gland beneath the sterno-mastoid on the right side and one or two smaller ones.

As the growth seemed to be irremovable he was put upon arsenic, and at the end of a fortnight there was a distinct improvement in the size of the cervical glands, and when last seen (March 27, 1906) the glands seemed to be still smaller, but the growth remained in about the same condition. The view I took of the case was that, from the situation of the disease, from its character, and from the enlarged glands, it was not worth while to submit the patient to an operation as it would be impossible to completely extirpate the disease. It may be added, moreover, that he has been operated upon successfully for cataract, and though fairly vigorous in other respects, this indication of senile change must also be taken as operating against interference. When shown at the meeting the growth projected towards the soft palate, having increased considerably.

The PRESIDENT said he regarded the case as inoperable, but possibly others might take a different view.

Dr. DUNDAS GRANT said the question arose whether the immobility of the right half of the palate was due to the mechanical pressure of the growth, or to involvement of the vagus nerve by the growth. Perhaps the President could say, if he had palpated it.

The PRESIDENT, in reply, said he thought the effect produced was mechanical; the palate was not infiltrated, but was very much pressed forward.

A WOMAN WITH LARGE SESSILE TUMOUR IN LEFT ARYTENOID REGION.

Shown by Mr. CARSON.

Dr. WILLIAM HILL said the cord moved very fairly on that side, and it occurred to him that it was not the arytenoid at all which was very much involved, but that the growth came from the upper and back part of the cricoid. If digital examination were made under an anæsthetic, it might be localised a little more certainly. It might be sarcoma.

Dr. SCANES SPICER said the condition might be ulceration of an encapsuled fibroma.

The PRESIDENT said he feared it was epithelioma of the pharynx, coming up from below and involving the arytenoid region in that direction. One could see a broad ulcerating surface, and it was very solid. To the finger it was not so hard as ordinary epithelioma. Epithelioma in a woman was particularly apt to involve that region. The present patient was older than most he had seen, and he thought but little could be done for the condition.

Mr. DE SANTI regarded it as a case of pharyngeal epithelioma similar to those described by Professor Gluck. The only thing which it was possible to do for the patient was to remove the whole pharynx and larynx, as Professor Gluck did. The patient, however, might not survive it.

Mr. CARSON, in reply, said there would be no difficulty in removing a piece of the growth for microscopical examination. That he proposed to do, and would report the result later.

A MAN WITH AN ULCERATED SWELLING IN THE MIDDLE LINE OF THE NASO-PHARYNX AND ULCERATION OF THE LEFT POSTERIOR FOLD OF THE PALATE.

Shown by Mr. CARSON.

Dr. DUNDAS GRANT thought the diagnosis lay between gumma and epithelioma. The intense hardness of the parts surrounding the ulcer suggested epithelioma, but the absence of pain was then rather difficult to explain. He did not think that feature excluded the diagnosis of epithelioma.

CASE OF FIXATION OF THE RIGHT ARYTENOID IN A WOMAN AGED FORTY ; FOR DIAGNOSIS.

Shown, in the absence of Dr. FURNISS POTTER, by Dr. DAVIS.

The PRESIDENT said he noticed that there was some movement of the vocal cord, while the arytenoid seemed fixed.

Dr. H. J. DAVIS said Dr. Potter, who was absent, was very anxious to have an opinion on the case. The symptoms had been in existence only eight months, and Dr. Potter thought it very peculiar that though

the arytenoid was fixed on that side the cord on that side moved. He (Dr. Davis) thought it looked like a mechanical partial fixation of the arytenoid.

A WOMAN AGED TWENTY-FOUR, WITH A SWELLING ON THE UPPER PART OF THE SEPTUM NASI; FOR DIAGNOSIS.

Shown by Dr. DONELAN.

Dr. DONELAN said the swelling had disappeared, and there was hæmorrhage, but that did not account for the fœtor. Yesterday there was a most unpleasant odour.

Mr. CRESSWELL BABER remarked on the deflection of the septum to the right side. The swelling which had existed on the left side was probably an influenza abscess of the septum.

CHILD AGED TWELVE WITH GROWTH ON THE LEFT SIDE OF THE TONGUE.

Shown by Mr. DE SANTI. This patient was sent to Mr. de Santi from the country for operation for adenoids and tonsils. On examination of the mouth it was found that the left side of the tongue was occupied by a papillary hypertrophy extending nearly all its length. The only inconvenience to the patient was the getting of the papillary mass in between the teeth. The condition of the tongue had not been noticed by the parents.

Mr. de Santi had never before seen so extensive a papillary hypertrophy of the tongue, and proposed to remove it with a knife.

Dr. H. J. DAVIS said that he considered the condition one of lymphangiectasis, though he was really indebted to others for the opinion.

The PRESIDENT thought it was a simple hypertrophy of the side of the tongue, because it did not collapse on pressure. He did not think it was more than a redundant fold, a congenital condition. The point which would decide as to removal would be the inconvenience caused. If it got bitten and bled it should be snipped off.

Mr. DE SANTI, in reply, said the condition got in the way of her teeth, but did not otherwise inconvenience her.

CASE OF INFILTRATION, WITH FIXATION, OF THE RIGHT VOCAL CORD IN A MAN AGED FORTY-SIX.

Shown by Dr. DUNDAS GRANT. The patient is a man aged forty-six, a printer, formerly in the habit of using his voice a great deal for public speaking and preaching. He was first seen on March 2, 1905, on account of hoarseness, almost amounting to loss of voice. There was then found a swelling of the anterior part of the right vocal cord and a small growth presenting the appearance

of a fibroma ; this was partially removed by means of forceps and several applications of the galvano-cautery. He was then lost sight of, and in October, 1905, appeared with a red general swelling of the right vocal cord, underneath which could be seen a small, apparently superficial, ulcer of oval shape. This unilateral infiltration of the vocal cord, with the shallow ulcer on its inner border, was looked upon as probably tuberculous, especially in view of the fact that two of his children were suffering from tuberculosis ; there was, however, no disease detectable in the chest, and the examination of the sputum revealed no tubercle bacilli. He was not again seen till yesterday, and then it was found that the infiltration extended into the ventricular band and that the mobility of the vocal cord was markedly diminished.

The exhibitor would be glad of opinions regarding the appearances which, although not characteristic of malignant disease, are certainly suspicious.

The PRESIDENT thought the case was in many ways the most important that had been brought forward at that meeting. It was difficult for him to be quite sure about it, but he thought the left vocal cord was a little œdematous. He asked how Dr. Grant would interpret the condition of the left vocal cord in its relation to the right, whether it was an accidental laryngitis or not.

Dr. STCLAIRE THOMSON said that if there had been no traumatism he would regard it as malignant fixation of the cord ; there was a purplish look about the whole cord.

Mr. ATWOOD THORNE said he understood that some of it had been removed by Dr. Grant. He would like to know if there had been any microscopical report on the portion removed.

Dr. GRANT, in reply, said the case was first seen a year ago, when it seemed to be simple granulation tissue. He did not think there was sufficient removed to enable a microscopical examination to be made.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND SIXTH ORDINARY MEETING, *May 4, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B. } Secretaries.
W. JOBSON HORNE, M.D. }

Present—39 members and 2 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were nominated for election at the next meeting as ordinary members—

JOHN DAVIS LITHGOW, M.B., C.M., F.R.C.S. Edin.
DUNCAN MATHESON MACKAY, M.D., C.M. Edin.

The following communications were made :

THREE CASES OF SYPHILIS IN ONE FAMILY, (?) COMMUNICATED BY
ORAL INFECTION FROM ONE TO THE OTHER ; WITH PHOTOGRAPH.

Shown by Dr. H. J. Davis. The three patients were exhibited. The first to develop syphilis was a child aged eleven. There was no evidence of genital infection, and she was a virgin, and first attended under his colleague Dr. Abraham, in the skin department of the West London Hospital last autumn, with a “ dusky, macular eruption on arm, legs, body ;—tonsillitis, severe adenitis, and enlarged glands in neck and groin, but no appearance of primary sore.” She was treated with mercury, and the rash soon vanished under treatment.

The child's grandmother, aged sixty—a widow fourteen years—nursed and slept with the child during her illness. Last December she became ill, and in February came under his (Dr. Davis') care, looking extremely ill with tonsillitis, adenitis, a typical rash,

and early iritis, and she was at the present moment suffering from virulent syphilis. There was no evidence of any primary sore.

A fortnight ago the child's aunt, who was inhabiting the same flat as the child and her grandmother, attended in the surgical out-patient department of his colleague Mr. Baldwin, with a chancre inside the right nostril; indurative oedema and adenitis were very marked, and the appearance was suggestive of malignant disease of the nose and upper jaw.

At the present time there were mucous patches on the tonsils, early roseola, and the primary sore could be seen at the junction of the skin and mucous membrane of the right nostril. There was still considerable infiltration and oedema, but the local conditions had subsided rapidly under mercury.

Dr. Davis thought the sequence of cases of great interest, and he had no doubt that the woman contracted the disease from her grand-daughter, and communicated it to her daughter by oral infection. Photographs of the three patients were exhibited.

The PRESIDENT asked if there was any history showing how the child became infected.

Dr. J. DONELAN also asked how the family became infected. He had occasion to look up the literature of extra-genital chancre lately, as during the past few years he had seen some cases in which the disease could not have been contracted in any vicious way, or by kissing, the only possible channel of infection being the use of spoons, etc., in a family where the foreign butler was suffering from buccal syphilis. Those who had to do with the foreign population of London must be struck with the number of cases of chancre of the tongue, and wonder that these extra-genital chancres were not more frequent now that restaurants were so much more frequented than formerly. The subject of extra-genital chancre was of much interest, and Sendziak had published a number of cases including chancres of the nose and ear. One of the most curious instances was that of a primary chancre of the pleura, reported by Dominicus. He desired to compliment their visitor Mr. Aslett Baldwin on his excellent photographs, which showed the great value of orthochromatic plates in recording morbid conditions.

Mr. ASLETT BALDWIN thought his case of chancre in the nose was of interest because of its rarity, and also because of its similarity to malignant disease; in fact, several who saw it at first suggested that diagnosis. When the woman was first seen, eight days ago, she looked and felt extremely ill, and had severe pain in the nose. She had been taking mercury for the above time, and was already much better. He thought the series of cases showed the importance of warning patients with syphilis that the disease is communicable.

Dr. DAVIS, in reply, said in July of last year the child went to a bean-feast, and the first symptom of syphilis that she had was severe tonsillitis. She was still taking iodides. Her grandmother, who slept with her, contracted the disease about Christmas, and had severe tonsillitis, but no

sign of a primary sore. A few months later a daughter attended Mr. Baldwin's out-patient department with a sore in the nose. Dr. Abraham, under whose care the child had been, had told him that it was not uncommon in South Africa for syphilis to run through a family without any evidence of a primary sore: they had simply tonsillitis and a rash. He had never met this in England.

FISH-HOOK REMOVED FROM THE ŒSOPHAGUS.

Shown by Dr. D. R. PATERSON. A boy, aged thirteen, swallowed a fish-hook about the size of No. 7 Limerick, and was admitted to hospital with the loop of the gut protruding beyond the teeth; on pulling on the gut pain was felt in the centre of the chest. A skiagram showed the hook impacted opposite the fifth dorsal vertebra. Chloroform was administered and an œsophageal tube passed over the gut into the gullet, where the hook was seen fixed in the wall to the left side. The long tubular end-piece of a saliva pump was now threaded over the gut and passed down so that its bulbous end rested on the point and barb of the hook. When the gut was pulled tight complete power was obtained over the hook, which was easily detached and removed.

TOOTH-PLATE REMOVED FROM THE ŒSOPHAGUS.

Shown by Dr. D. R. PATERSON. The patient, a woman aged thirty-six, swallowed, during sleep, a tooth-plate having four teeth and two hooks or clasps. A skiagram showed it opposite the supra-sternal notch. Fortunately no attempt had been made to dislodge it by probang. An œsophageal tube was pressed down and the plate was removed by the straight laryngeal forceps.

SKIAGRAM OF THE NECK IN A CASE WHERE A PIECE OF MEAT WAS IMPACTED IN A STRICTURE OF THE GULLET.

Shown by Dr. D. R. PATERSON. This case was a lad who had "a small swallow" for some time. In the attempt to swallow a piece of meat it stuck in the gullet and blocked it so that nothing could be passed. Attempts were made by probang and coin-catcher to push the obstruction down, and considerable force was used without result. Twenty-four hours afterwards on admission to hospital the lad looked very ill, had a high temperature and a rapid pulse, and much swelling on the left side of the neck, with distinct emphysematous crackling. He was quite unable to swallow

anything. Under chloroform great swelling and œdema of the entrance of the œsophagus and about the left pyriform sinus were seen. An œsophageal tube was passed, and opposite the cricoid cartilage an impacted piece of beef was removed. There was narrowing of the gullet at that point. Swallowing was at once re-established. Gradual recovery took place. Considerable damage had been inflicted by the probang and coin-catcher, and this case indicated that their indiscriminate use should be discouraged, more especially as we have now instruments of precision.

LEFT RECURRENT PARALYSIS AND PARALYSIS OF THE SOFT PALATE
ASSOCIATED WITH MIDDLE-EAR DISEASE AND FACIAL PALSY ON
THE SAME SIDE.

Shown by Dr. D. R. PATERSON. A female, aged twenty-four, noticed deafness in the left ear which was followed by facial palsy three or four weeks later. Six months later still weakness of voice was observed, with occasional uncertainty in swallowing. This has remained practically unaltered. At the present time the left recurrent nerve is paralysed and the soft palate is weak on that side. There is complete left facial palsy. She hears nothing in the left ear; the bone-conduction is increased and the inner part of the meatus is swollen and has a vivid red appearance. No details of the membrane can be made out, the swelling being somewhat resistant to the probe. There is no headache, and the eyes are normal. She has been under observation for two months and there has been no apparent change.

Dr. DUNDAS GRANT, referring to the case of recurrent paralysis, said the later history would be very important. There was a combination of nerve-lesions which pointed to something near the apex of the petrous bone, such as might be due to tubercular disease or to new growth. But with regard to the latter there was a singular absence of glandular enlargement in the neighbourhood. He asked whether there was anything in the naso-pharynx or in the history to account for it.

Mr. BARWELL asked whether the ear-drum was normal and whether the deafness was of the nerve or the middle-ear type. He did not understand whether there was suppuration in the middle ear when the attack of facial paralysis came on or whether it was nerve-deafness arising at the same time as the lesion of the other nerves.

Dr. STCLAIR THOMSON said he had a case, of which his memory was somewhat hazy, about eight years ago, the record of which was in the *Clinical Society's Transactions*. It was somewhat similar to the present case. The patient was a man aged thirty-six, and was brought because of difficulty in swallowing; there was paralysis of the recurrent laryngeal nerve on the left side. The history given was that one year and a half

previously the patient was under Dr. Urban Pritchard for Ménière's disease. He had a thickened, red, bulging drum, and nerve-deafness on that side. The case at first was taken to be early malignant growth of the oesophagus; the condition of the ear was thought to be merely a coincidence; and the symptoms in the ear and the throat were not regarded as associated. He died of an intra-cranial growth. There were no enlarged glands and the progress of the case was remarkably slow.

Dr. DONELAN thought the case was of centric origin, perhaps due to a tumour affecting the pons or embolism in that region, as it appeared to be an irregular form of Avellis' well-known group of symptoms. Where the palate and vocal cord alone were associated the lesion was generally peripheral. A number of cases had been recorded where paralysis of the shoulder was associated with that of the palate and vocal cord. He had not seen any case in which the facial was included, but he believed some rare cases reported by members of this Society are referred to in Professor Poli's excellent paper in the current number of the *Italian Archives of Laryngology*. He thought the engorgement of the tympanum was due to implication of the sympathetic.

Mr. CLAYTON FOX asked if there had been any giddiness. It appeared to suggest sarcoma of the dura mater, starting from the posterior part of the petrous bone, involving the seventh, eighth, and ninth, and vago-accessory nerves. The patient had distinct difficulty in swallowing.

Dr. WILLIAM HILL said he did not think it was made clear whether the auditory nerve was involved. Possibly the middle-ear disease had nothing to do with the nerve-lesion which had produced the facial paralysis and the affection of the recurrent laryngeal.

Dr. PATERSON, in reply, said there had been nothing in the nasopharynx, nor any suppuration in the ear. She heard nothing on that side, and bone-conduction was increased there. It appeared as if the middle ear were pushed out; the swelling on the floor of the meatus was distinctly hard to the probe. Therefore he did not think vaso-motor changes would account for it. There was no giddiness, and the onset of the deafness and the facial palsy were practically simultaneous. She had been having 30 gr. a day of iodide of potassium during the past two months, but without any change, and, according to the patient's account, there had been practically no alteration in two years.

The PRESIDENT said it was possible there was a growth, and members would be glad to hear the after-history of the case.

BILATERAL ULCERATION OF THE POSTERIOR SEGMENTS OF THE VOCAL CORDS IN A MAN.

Shown by Dr. H. PEGLER. There had been temporary improvement under iodide of potassium.

Dr. DUNDAS GRANT thought it was a beautiful case of pachydermia. The patient had been a vegetable dealer, and a hawker previously to that, occupations leading to excessive strain on the vocal cords.

The PRESIDENT also thought it was a case of pachydermia because of the mobility of the cords and the depressed points, with soft tissue round them and the way in which they became flattened. The patient was young for it, but perhaps that did not matter if the habits were sufficient.

Dr. H. PEGLER expressed his thanks for Dr. Grant's opinion, which accorded to a certain extent with his own view, though the depth of the ulcerations had prevented his regarding it as a typical form of pachydermia. The appearances had altered somewhat from time to time.

A NEW NASAL SAW.

Shown by Dr. E. A. PETERS.

The PRESIDENT asked what was the object of the concavity of the saw. Mr. H. TILLEY asked what class of case Dr. Peters used the nasal saw for.

Dr. PETERS, in reply, said the saw was very rigid, and the concavity fitted in with the direction of the cut. He admitted that submucous dissection had made a good deal of difference in operating, but there were some cases, particularly where there was a spur from the floor of the nose, in which removal was difficult by the submucous method. He thought there was still room for a saw.

FOUR CASES OF CHRONIC FRONTAL EMPYEMATA OPERATED ON BY A SIMPLIFIED KILLIAN OPERATION.

Shown by Dr. HERBERT TILLEY. CASE 1.—Child aged six and a half, who had already been operated upon for chronic suppuration of the lacrymal sac (left). The fronto-ethmoidal cells were in an empyematous condition.

CASE 2.—Young adult, aged twenty-five, dermoid cyst over right eye, beneath external angular process. Nasal suppuration present, and found to be due to chronic empyema of right maxillary antrum. Frontal sinus healthy.

CASE 3.—Female, aged twenty-three. Bilateral fronto-ethmoidal empyemata. The left side treated by older method, viz. free opening of sinus, followed by "packing," the right by a simplified Killian operation, with immediate closure of the wound.

CASE 4.—Male, aged fifty-three. Chronic empyemata of left fronto-ethmoidal sinuses. Simplified Killian operation. Immediate closure of wound. Discharged from hospital eight days after operation. Almost total absence of visible scar.

The "simplification" referred to consists in leaving the floor of the frontal sinus untouched, otherwise the procedure is the same as in Killian's operation.

Dr. DUNDAS GRANT said he did not think Killian always removed the floor of the frontal sinus. He (Dr. Grant) agreed with Dr. Tilley, that removing the floor added considerably to the laceration, and if such results were obtainable in all cases without removing the floor, it was

very desirable. In a recent case he used exactly the method shown by Dr. Tilley, and when it came to be a question of removing the floor, he felt he would rather leave it alone, as it added to the difficulty of an operation already not simple. The case eventually did very well. The friends were delighted with the absence of deformity. The great point which Killian had brought out was the ingenious method of preserving the bridge along the upper margin of the orbit, and the elderly man in Dr. Tilley's series showed how perfect the result might be in regard to disfigurement. The scar in the little girl was more prominent, though in time that might disappear. Perhaps the healing was complicated by the suppuration in the lacrymal sac. Whether the floor was removed or not, one should practise the preservation of the bridge over the margin of the orbit and the opening through the ascending process of the superior maxilla. Those who had not done this could have no idea of the magnificent access it gave to the ethmoidal cells.

Dr. SCANES SPICER said that in many such cases the procedure was attended by much scarring of the face. He thought that equally good results could be obtained by the less extensive operations which were generally adopted eight or ten years ago. The scars on the faces of the woman and girl shown to-day were both serious. Of course, if one had operated two or three times by removing the middle turbinate body, destroying the ethmoidal cells, and doing the old operation followed by trephining the anterior wall and curetting, then if necessary, one might justifiably go on to extirpation of the lower part of the cavity. One should be very guarded about saying a frontal sinus case was *cured* if there was no pus seen. He had been deceived in many cases in that matter. Even nine months after an apparent cure a cold seemed to light up the whole thing again. He was not clear why the term "dermoid cyst" was applied to one case. He understood the frontal sinus was not suppurating, but he had seen one or two similar cases which had led into the frontal sinus, owing to the extension of that sinus outwards.

Mr. STUART-LOW said there was no scar in Killian's cases, whose results were marvellous, and this was largely due to his skill in bringing the edges accurately into apposition by means of aluminium wire sutures. He made slight transverse incisions at intervals simply through the cuticle, so that he might more readily and directly appose the edges in stitching up. It was altogether incorrect to say that because Killian removed the floor of the frontal sinus diplopia frequently followed. Diplopia seldom happened even when the trochlea was removed, which occasionally occurred. He confessed to a feeling of disappointment since examining these cases as the scarring amounted to permanent disfigurement, and it was questionable whether a radical remedy had been effected.

Mr. HERBERT TILLEY, in reply, said whether as good results could be obtained with a smaller operation depended on the nature of the case. If there was extensive infection of ethmoidal cells a larger operation must be performed than when the frontal sinus was alone diseased. Dr. Spicer had said that in some of the patients shown there was still a complaint of a purulent discharge. In the case of the boy who had the dermoid cyst the radical maxillary operation was performed on the right side only ten days ago, and the secretion he complained of was merely the mucus from the granulating cavity, and as the frontal sinus was not affected in this case it was scarcely fair to speak of it as "still discharging." In reply, again, to Dr. Spicer, a dermoid cyst was spoken of because there

was a large tumour pressing the eyeball downwards and outwards, and when it was opened cheesy material came away, which the microscope showed to consist of the contents of a dermoid tumour. This patient showed a considerable deformity, but that was entirely due to the dermoid cyst and had nothing whatever to do with the sinuses. He was not ungrateful to Mr. Low for his criticisms, and he (the speaker) felt that the operative procedure upon the sinuses had not been reduced to perfection. His recent cases, he thought, would show as good results as could be wished. If more care were taken in suturing the external wound he thought as good cosmetic results would be obtained here in London as elsewhere. He would be quite content if he could always obtain as good a result as was exemplified in the case of the man shown to-day. The little girl's case was, again, scarcely a fair one to criticise from the point of view of the operation on the frontal sinus, because not only was it recent and had not had time to heal, but when the patient was transferred to him there was a suppurating fistula over the lacrymal sac and the surrounding skin in a state of inflammation, so that he was operating on a case which was unfavourable to start with. If he had been intent on showing his best results from the cosmetic point of view, he would have brought forward only the man on whom he operated last week, and who had had no previous operations performed.

A CASE OF TUBERCULOSIS OF THE SOFT PALATE, THE PHARYNX, AND THE EPIGLOTTIS.

Shown by Mr. CLAYTON FOX. On April 11, 1906, a woman of delicate appearance, aged thirty-two, was admitted as an in-patient at the Metropolitan Nose, Ear, and Throat Hospital, complaining of sore throat, pain on swallowing, cough, and accumulation of phlegm, of seven months' duration (she had previously been treated as an out-patient).

Family history.—One brother had had three attacks of pleurisy; all other members of family healthy. No history of phthisis, syphilis, gout, or rheumatism.

Previous history.—Her health had been good till last August, when the throat began to trouble her. Two children born alive, both very weakly. One miscarriage, four years ago.

On admission.—There were several greyish-white hemispherical nodules on the pillars of the fauces and velum, especially above and on either side of the base of the uvula; some had broken down, leaving roundish, shallow ulcers with grey bases, and devoid of any reactionary areola.

Where the posterior pillars of the fauces shade off into the pharyngeal wall there was on either side an elongated, shallow ulcer with greyish-yellow speckled base and irregularly-shaped

nibbled edge, the latter slightly raised above the neighbouring mucosa. The left anterior pillar had a clean, red, nibbled appearance, no slough being present. There was marked pallor of the mucosa of the hard palate, velum, and fauces. There were two small ulcers elongated in shape and having an eaten-out look on the laryngeal aspect of the free border of the epiglottis. Both arytenoids and the right ventricle bands were swollen. Some of the upper deep cervical glands of the left side were slightly enlarged. An examination of the lungs revealed some impairment of resonance over the upper right lobe. Inspiration was wavy, with prolonged expiration over this area, whispering pectoriloquy was present. Sibilant rhonchi on expiration were present on some days over the whole of the right lung. There were no other adventitious sounds. Patient has had a temperature of remittent type since February 28, accompanied by night-sweats and loss of flesh. Sputum has been examined on two occasions, with a negative result. On April 18 attention was called to an ulcer on the posterior part of the left labium majus, elongated and oval in shape, the base covered with pale granulations and edge indolent and livid. Neither the base of this ulcer nor the tissues around were indurated. The inguinal glands on the same side were slightly enlarged. The post-nuchal, the suboccipital, the epitrochlear, and the glands generally were not enlarged. There was no rash present. Patient has been treated with iodide of potassium and quinine, also with iodide of potassium and mercury. Locally a mixture of carbolic acid, formalin, and lactic acid has been rubbed into all the ulcerated parts, and vapour creosoti has been inhaled.

The chief points of interest in this case are:

(1) As to whether the pharyngeal and laryngeal lesions are the result of one syphilitic inoculation.

(2) Are the lesions pharyngeal and vulvar tubercular?

(3) Is the vulvar sore a chancre, the secondary symptoms not having yet appeared?

(1) It would be difficult to reconcile the fact that a sore of two months' duration could be associated with such pronounced pharyngeal and laryngeal ulceration without other manifestations of secondary syphilis, rashes, mucous tubercle, systemic glandular enlargement, etc., conditions absent in this case.

(2) Appearances of the lesions and symptoms favour the idea that all the lesions may be tubercular.

(3) Against the vulvar sore being a chancre we are confronted with the facts that it is not indurated, and that although of two

months' standing, the usual secondary phenomena are conspicuous by their absence.

Mr. BARWELL regarded it as tubercle alone.

Mr. CLAYTON FOX, in reply, said he thought it was tuberculosis of the pharynx and epiglottis. His only doubt concerned the lesion on the vulva, which was of two months' duration, and which, except for the absence of induration of the sore and the enlarged inguinal glands, presented the characters of chancre. Against that was its two months' existence, and the absence of secondary phenomena. None of the systemic glands were affected.

A CASE OF SWELLING BELOW THE ANTERIOR COMMISSURE OF THE VOCAL CORDS, CAUSING SOME DYSPNŒA, WITH DEFORMITY OF THE EPIGLOTTIS AND INDURATED SWELLING OF BOTH AURICLES IN A WOMAN AGED FIFTY-FIVE.

Shown by Mr. CHARLES PARKER. The patient had lived in India for two years and in Italy for one year. Eight years ago, after her return from India, she was out on a very cold night, and the left ear suddenly became extremely painful. The pain passed off within twenty-four hours, but the ear gradually enlarged and became very hard. Five years ago, whilst in the mountains of Italy and exposed to great cold, the right ear became similarly affected. For the last two months the patient has suffered from severe cough and the sensation of something in the region of the larynx which she could not expectorate, and for the last six days she has had distinct dyspnœa. At the present time both auricles are enlarged and deformed and of almost bony hardness, and the skin is white and shiny. The auditory meatuses are somewhat contracted, but there is no disease of the tympanic cavities, and the hearing is good. The nose is altered in shape, being more or less of the saddle-back shape; the nasal cavities are normal, except for some thickening of the cartilaginous septum. The naso-pharynx and ovo-pharynx are normal. The epiglottis is of a peculiar shape, thickened and distinctly yellow in colour, suggesting cartilaginous thickening. Abduction of the vocal cords is limited. Below the anterior commissure of the cords a red swelling can be seen extending to the trachea and more towards the left than the right side. In the neck some thickening and great hardness can be felt on the left side over the first few rings of the trachea. There is audible dyspnœa on the slightest exertion and noisy breathing during sleep. The case is shown for the purposes of diagnosis and to elicit opinions as to whether the condition of the ears and the laryngeal changes are due to one cause.

Mr. BUTLIN said he could not be sure about the laryngeal and infralaryngeal trouble, but thought there was some thickening to be felt from the outside. He had not seen anything like the ear condition in his life. The only condition which it seemed at all to resemble was that which sometimes occurred in the penis of gouty people—a carapace of firm, fibrous material. He had removed more than one of these, and the microscope showed fibrous tissue, perhaps due to degeneration. He did not regard it as a new growth.

Dr. DAVIS said he thought it resembled leprosy. There was infiltration, facial deformity, and silkiness of the skin of the hands, which were characteristics of the disease.

VILLOUS PAPILLOMATOUS GROWTH, PROBABLY EPITHELIOMA (BUT WITH DOUBTFUL HISTOLOGICAL CHARACTERS ; A HISTORY OF OLD SPECIFIC INFECTION ; ANTI-SPECIFIC REMEDIES NOT YET TRIED), IN A MAN AGED FORTY-SIX.

Shown by Dr. DUNDAS GRANT. The patient complained of pain in swallowing, dryness of throat, which had gradually developed and had lasted two years, while during the last three months there had been some bleeding from the throat. On laryngoscopical examination the cavity of the larynx was almost completely hidden by a red papillated mass of globular form, which at first sight appeared to be growing from the laryngeal surface of the epiglottis. During inspiration and phonation the right half of the larynx seemed to move, and after the extraction of a portion of the growth it was seen that the right vocal cord was normal, both in colour and mobility. The growth when moved by means of a probe appeared to be attached to the left half of the vestibule of the larynx, and several portions of it were removed by means of the snare. It was then seen that the left vocal cord was almost completely fixed, but free from ulceration of any kind. The voice was practically normal, and there was little or no interference with respiration. Microscopical examination of a small portion, removed by means of forceps, revealed thickened epithelium with œdematous infiltration, but no definite signs of malignant and neoplastic process ; a large portion removed more recently possessed characters more suggestive of malignant disease, which will be described by Dr. Wyatt Wingrave. There was some enlargement of glands at the angle of the left jaw. The laryngoscopic appearances are highly suggestive of epithelioma, and this is supported by the history of the disease, but the microscopical appearances are so little confirmatory, that the exhibitor thinks it advisable to try the effect of anti-specific remedies in view of the former infection, on

the chance of the growth being one of the proliferated forms of syphiloma. He hopes to show the case again at the next meeting.

PREPARATIONS ILLUSTRATING DR. DUNDAS GRANT'S CASE OF LARYNGEAL GROWTH.

Shown by Dr. WYATT WINGRAVE. Fragments weighing 98 grains were removed at two sittings. They were soft and friable in consistence, mammillated and translucent in appearance.

Microscopically they consist of closely packed spheroidal cells, apparently derived from the surface epithelium of the cords from which they can be traced. The cells are grouped in large masses, separated by a very scanty stroma. Their nuclei are strikingly variable in size, many being four times as large as those of normal squamous epithelium. Mitoses are few and of a somatic type. Extra-cellular chromatin granules are few, lymphocytic infiltration is absent, and there are no concentric "pearls" or "nests."

It is evidently an epithelial growth, papillomatous in type, possessing, however, some striking variations from an ordinary papilloma, yet wanting the definite characters which constitute unequivocal histological malignancy.

Dr. WYATT WINGRAVE thought it was the kind of case in which the histologist could justifiably ask the surgeon to share the responsibility of the diagnosis. There were unmistakable signs of papilloma and an absence of the features of typical epithelioma. The cells possessed remarkably large nuclei, and there was no evidence of mitosis other than was found in somatic cells. The surface was distinctly mammillated, and before going into alcohol presented translucent characters more suggestive of papillary growth than epithelioma. One was justified in being suspicious of the case, because the enlarged nuclei were suggestive of a transition stage from innocence to malignancy.

Mr. BUTLIN said he had examined the case and had come to the conclusion that the condition was one of marked malignant disease. It was partially hidden by a large swelling above, and he thought that possibly Dr. Wingrave had not had a sufficiently characteristic piece to examine. The glands on both sides of the neck were very characteristic of malignant disease. It was, he thought, a hopeless case.

Mr. ROBINSON said he had come to the same conclusion as Mr. Butlin. He thought it undesirable to attempt its removal.

Dr. DUNDAS GRANT, in reply, said the only thing which threw doubt on the diagnosis was the microscopical appearance. The specimen for examination was obtained from deep in the growth, but possibly the characteristic changes would be found deeper. On the chance of its being specific, he proposed giving a course of iodide of potassium and mercury, the effect of which would soon show itself.

CASE OF EPITHELIOMA OF THE PALATE IN A MALE PATIENT AGED SIXTY.

Shown by Dr. DUNDAS GRANT. There is a shallow, oval ulcer of about the size of a shilling, chiefly on the left half of the soft palate but encroaching on the hard. The base of it is not materially indurated, but the edges are distinctly hardened and show a slight tendency to eversion. The patient complains of pain in his mouth, especially when eating or drinking, which has come on gradually and has lasted, as far as he can judge, for about three weeks. The bacteriological examination reveals a few curved spirals of about four turns, fusiform bacillus, and some non-pathogenic organisms; but the bacteriologist, Dr. Wingrave, is unable to say that the *Spirochæte pallida* is present; such epithelial cells as were found in the scraping were normal. There is a hard mass of glands beneath the mastoid insertion of the left sternomastoid muscle. When first seen, three weeks ago, he was ordered 10 gr. of iodide of potassium with a drachm solution of perchloride of mercury, and on the 28th the dose of the iodide was increased to 25 gr.; the induration of the edges of the ulcer has increased in the interval, and the diagnosis of epithelioma is probably correct. Extirpation of the growth and of the glands is proposed.

Mr. ROBINSON thought it an interesting example of the superficial form of epithelioma. Some of those who saw it were suspicious that it might be specific, but he felt no doubt that it was epithelioma. He had several times removed such a condition.

Dr. STCLAIR THOMSON said he did not know whether Dr. Grant thought of operating upon the case with such extensive glands in the neck. He (Dr. Thomson) thought it was much too extensive. It was very much like a case he had in which, bearing out what Mr. Butlin said, pieces were removed for examination and reported to be papilloma, but in which one did not get down to the real growth. His case was shown at the Clinical Society, when all agreed that it was quite inoperable.

The PRESIDENT said the disease did not seem to have broken through the capsule of the glands, and in such cases the glands were removable. Such palate cases were very favourable for operation, and if it were surgically possible to operate on the case he thought it ought to be done. He judged that it was suitable for operation, the glandular operation being done first, and if the patient bore that well, finishing up with the palate, which could be done in a few minutes.

CASE OF MYCOSIS OF THE SOFT PALATE.

Shown by Dr. HERBERT TILLEY. Male, aged forty-two, with an area of inflamed mucous membrane on the soft palate immediately

above the right tonsil—the area referred to is covered with what appear to be some twenty pustules about the size of a hemp seed. Patient complains of some pain in swallowing, or when the tongue is depressed. There is no history or signs of tubercle or syphilis in other parts of the body. Symptoms have been present for seven months.

The PRESIDENT thought the appearance was allied to that of the condition called leukoplakia; the formation in small, isolated spots he had found not uncommon on the palate. The condition, he thought, might have a syphilitic basis. He had seen this condition on the mucous membrane beyond the margin of an epithelioma, and though this condition might exist for some years, he thought it was better to remove the mucous membrane in the present case in view of the possibility of an epithelioma developing.

Mr. STUART Low said he had come to the conclusion that this was a case of epithelioma. The patient complained of pain on swallowing, on palpation through the mouth the pain was considerable, and a certain amount of induration could be felt.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ONE HUNDRED AND SEVENTH ORDINARY MEETING, *June 1, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

HENRY J. DAVIS, M.B. } Secretaries.
W. JOBSON HORNE, M.D. }

Present—18 members and 4 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected as ordinary members—

JOHN DAVIS LITHGOW, M.B., C.M., F.R.C.S.Edin.
DUNCAN MATHESON MACKAY, M.D., C.M.Edin.

REPORT OF MORBID GROWTHS COMMITTEE.

(1) Dr. Brown Kelly's specimen of Hyperplasia of the Uvula, shown December, 1905. The Committee agreed with this description.

(2) Mr. Stewart Low's specimen of Naso-pharyngeal Growth, shown February, 1906. The Committee considered the specimen to be one of carcinoma.

The following communications were made :

CASE OF INOPERABLE CANCER OF THE FAUCES, THE PHARYNX, THE TONGUE, AND THE CERVICAL GLANDS THAT HAS SHOWN MARKED AMELIORATION AFTER TREATMENT FOR TEN WEEKS WITH A BACTERIAL VACCINE OF NEOFORMANS.

Shown by Dr. SCANES SPICER. The patient, a Balaclava veteran, aged seventy-five, was sent to the Throat Department of St. Mary's Hospital in March, 1906, by Dr. W. T. Evans for an ulcerating growth in the throat and enlarged glands in the neck. The tumour occupied

the site of the left tonsil, the faucial pillars, the side of the tongue, and extended down the wall of the pharynx. It blocked the faucial isthmus sufficiently to prevent laryngoscopy even with the smallest mirror, but there was no affection of phonation or respiration. The tongue could not be extruded. The surface of the growth was studded with bloated fungous granulations imbedded in copious brownish-yellow foetid fluid on an ulcerated purplish base; there was a large mass of swollen hardened glands behind the angle of jaw. There was considerable dysphagia and much pain in the left side of the head and the ear, on trying to swallow. He had lost much weight lately but could not say how much. The case was diagnosed as malignant and inoperable—a view in which Mr. A. J. Pepper concurred. A portion of the growth was removed from the tonsillar area. Iodide of potassium, gr. xv three times a day, and an antiseptic gargle were given for a week. As no improvement was observed this was stopped; and the Pathological Department having reported that the growth was a spheroidal-celled carcinoma, the patient was sent to the Inoculation Department with a view to treatment by a bacterial vaccine by Professor A. E. Wright. This was carried out as shown by the accompanying chart indicating the doses, intervals of injection, and the opsonic reaction of the blood. The condition of the fauces and the glands was regularly and carefully observed by Dr. Scanes Spicer. The favourable changes commenced at once and continued to increase for five or six weeks, after which there was no further improvement, but no regression. The patient lived at home, and walked to the hospital for treatment. The changes observed were—(1) diminution in the size of the faucial mass, so that laryngoscopy became possible; (2) lessening of the ulcerated surface, and the unhealed part looking like a healthy granulating surface; (3) disappearance of the bloated granulations; (4) loss of foetus; (5) disappearance of dysphagia and pain in the throat; (6) the tongue became less rigid; (7) the external mass shrunk down enormously, leaving one small hard gland. No other treatment was used. Whenever the opsonic power was low the patient invariably complained more of head pains. No opinion was tendered as to whether the treatment had influenced only secondary ulcerative and septic processes or the malignant substratum itself, nor did it seem determinable what were the proportions which these factors bore in the sum total locally. The whole improvement was nevertheless marvellous both locally and in the patient's general condition, and the case was of good augury for the in-

fluence of the method. A cure was not claimed, and the patient was shown as still under treatment in case unfavourable changes should supervene before next session. The clinical record was incomplete, but the history and stigmata of syphilis were negative.

The PRESIDENT said he had been much struck by the condition of the part at the present time; it was so clean and free from odour, and from the description of the condition given by Dr. Scanes Spicer, they were able to appreciate the value of the treatment.

REMARKS EXPLANATORY OF THE TREATMENT.

By PROFESSOR A. E. WRIGHT, F.R.S.

PROFESSOR A. E. WRIGHT said that he had gladly come in response to Dr. Scanes Spicer's invitation to explain to the Society the rationale of what had been done in connection with the treatment of this case.

Dr. Doyen, as was well known, had asserted that there could be obtained by culture from all, or practically all, new growths—whether of a malignant or a non-malignant nature—cultures of a characteristic microbe. This microbe was, by Doyen, regarded as the specific cause of cancer on the ground that it produced in his hands when inoculated into rats neoplastic lesions. It was accordingly named by Doyen the *Micrococcus neoformans*. While those who have seen Doyen's sections of the lesions obtained by him in rats by the inoculation of cultures of his *Micrococcus neoformans* do not, so far as I know, agree in the view that the lesions he produced were of the nature of new growths, there can be no doubt of the singularity of the pathological changes which are here in question. In specimens given to me by Dr. Doyen the whole upper lobe of the rat's lung has been converted into a mass of cartilage. Here and there through the rest of the lung are scattered large masses of embryonic cells—perhaps only scar-tissue. Interspersed with these are masses of epithelial tissue somewhat resembling adenomata—possibly only large epithelium-lined diverticula taking origin from the bronchi. However this may be, Metchnikoff first, and after him many others—including some of my fellow-workers at St. Mary's Hospital—have confirmed Doyen's statement that a characteristic microbe—the *Micrococcus neoformans* can be obtained by culture from tumours. The microbe in question has a superficial resemblance to the staphylococcus. It differs from it, however, in the following particulars:

(1) When first taken from the body it gives only very sparing cultures on ordinary agar.

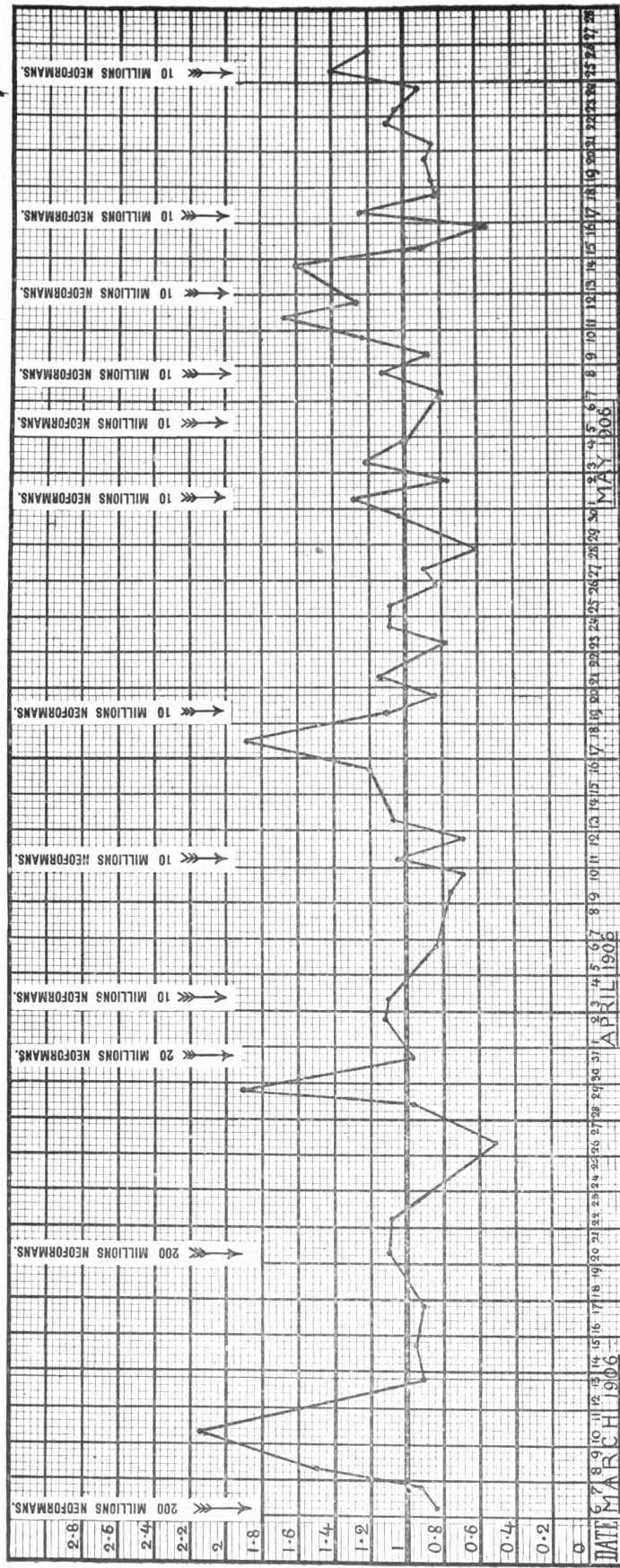


Chart to illustrate Professor Wright's remarks explanatory of the treatment of Dr. Scanes Spicer's case of inoperable cancer of the fauces.

(2) In film preparations it is arranged, not in clusters like the staphylococcus, but in short chains, and in particular in Y-shaped figures—*i. e.* in short bifurcating chains.

(3) It is agglutinated by normal human serum,¹ even when this has been diluted two hundred or more times.

(4) The *Micrococcus neoformans* can be further differentiated from the staphylococcus by the fact that a blood which possesses—whether as a result of artificial or auto-inoculation—a high opsonic power with respect to the *Micrococcus neoformans* may possess a low opsonic index with respect to the staphylococcus; and *vice versâ*.

A scientific basis for the differential diagnosis of the *Micrococcus neoformans* having thus been obtained, and having verified by these means that a culture of the *Micrococcus neoformans* supplied by a Belgian observer—Geets—corresponded in all respects with two cultures² obtained by us at St. Mary's; we have recently begun to address ourselves to the task of investigating the opsonic and agglutinating power of the victims of malignant disease with respect to the *Micrococcus neoformans*.

It will suffice to say with respect to the agglutinating and opsonic powers of the victims of malignant disease that these differ from the normal (1) in the fact that they are lower and in others much higher; (2) in the fact that the opsonic index is in some cases constantly fluctuating as it does in cases of bacterial infection which are associated with constitutional disturbance; and (3) in the fact that phagocytosis is in some cases obtained with the serum after it has been heated to 60° C. for ten minutes. We have here, it seems to me, ground for concluding that infection by the *Micrococcus neoformans* is one of the factors which must be reckoned with in connection with malignant disease.

The case Dr. Scanes Spicer has shown to you is one of a first batch of five cases in connection with which we have undertaken inoculations with a vaccine consisting of a sterilised and enumerated culture of the *Micrococcus neoformans*.

¹ The fact that some of his cultures of the *Micrococcus neoformans* were agglutinated by normal serum is incidentally noted by Karwacki (*Centralblatt für Bakteriologie*, vol. xxxix, (Originale), p. 369, 1905) as a complication which presents itself in connection with the appreciation of the value of the agglutination obtained by him with the blood of cancer patients. The fact that the *Micrococcus neoformans* is agglutinated by every normal human serum while the staphylococcus is not so agglutinated appears to have been overlooked by this observer.

² The first of these cultures was obtained by Dr. Loveday from the interior of a breast amputated for carcinoma, the second by Dr. May from the discharge from an ulcerated surface of an epithelioma in the glands of the neck, secondary to epithelioma of the tongue.

It is the only case in which we have had a striking result. Of the other four cases two have already died. Of the two others one appears to be quite stationary, while the other shows marked signs of improvement.

The PRESIDENT said the members had already shown their appreciation of Dr. Wright's lucid though brief account of the method he had adopted in the case and the progress of the investigation up to the present. They would agree that no one was better qualified to extract whatever was of good in the method than Professor Wright.

A CASE OF INFILTRATION OF THE LEFT VOCAL CORD.

Shown by Mr. H. BARWELL. The patient, a male nurse, aged fifty-three, had been suffering from hoarseness and frequent aphonia for eleven months, and much pain on swallowing solids for four months; there was slight inspiratory stridor. There was some frothy expectoration, with occasional small streaks of blood. Examination of the chest revealed bronchial breathing and increased vocal fremitus and resonance over the entire upper lobes of both lungs, but the physician who examined him did not consider the signs distinctive of phthisis. The left cord was occupied for its anterior two thirds by a dark red, papillary swelling; the posterior third was red, the cord was fixed near the cadaveric position, and the left arytenoid was slightly swollen, having the appearance of inflammation about the joint rather than tuberculous infiltration; there was a small excrescence in the interarytenoid space to the right of the middle line. There appeared to be some subglottic swelling extending across the anterior commissure to the right side.

The patient had only been examined once in the out-patient room; his sputum had not been examined nor had a temperature chart been kept. Mr. Barwell thought the case might interest members from the point of view of laryngoscopic diagnosis and he desired opinions on the subject.

Mr. CRESSWELL BABER said he thought there was ulceration, and that the prominence on the left arytenoid was the edge of an ulcer. If antisyphilitic treatment had not yet been tried, he recommended that it should be ordered.

Dr. STCLAIR THOMSON regarded the case as distinctly one of tubercle, because of the infiltration of the interarytenoid, the prominent mammillary surfaces, and the great loss of part of the vocal cord and the adjoining ventricular band.

Mr. BARWELL, in reply, said he refrained from expressing an opinion, but he had so far committed himself as to arrange to take the patient into the Mount Vernon Hospital for Consumption.

A CASE OF PALATAL TUMOUR OF TWENTY YEARS' DURATION.

Shown by Dr. J. W. BOND. The patient was a woman aged sixty-five. The tumour first appeared twenty years ago, and was a small warty growth. Twelve years ago it was operated upon at the London Homœopathic Hospital. The growth remained absent for eight years. Since then it has been growing until it has reached its present size. There was never any pain until lately. There had been considerable hæmorrhage during the last few weeks. The patient was getting very weak. The disease extended into both nostrils. There had been considerable blood and watery discharge from the nostrils lately. The maxillary antra were both absolutely dark. No glands could be felt in the neck. The pain had been greatly relieved by iodide of potassium, 5 grs. three times daily.

No microscopical specimen of growth was shown, nor had the diagnosis been obtained of the tumour that was removed.

The PRESIDENT thought it must be a large sarcoma; it was evidently not an epithelial new growth.

A CASE OF EPITHELIOMA OF THE TONSILS.

Shown by Dr. E. A. PETERS. The patient, an old soldier, aged fifty-five, when seen in June, 1905, for two months had been aware of a lesion which appeared as a round ulcer half an inch across situated on the right tonsil and anterior pillar. Microscopical evidence indicated epithelioma. The ulcer improved slightly under iodide of potassium and then relapsed.

July 6, 1905.—Through an incision along the sternomastoid a few glands were removed which appeared quite healthy; the external carotid was then tied.

July 13, 1905.—Ten c.c. of antistreptococcal serum were injected and the patient anæsthetised and placed in the Trendelenburg position with extended neck. A preliminary laryngotomy was carried out and the pharynx plugged with a soft sponge. The cheek was split and the soft palate was divided. An incision beyond the margin of the œdema was made, the pharyngeal wall was separated from its connections, with the tongue, hard palate, and mandible. The bone immediately under the œdema was chiselled away. Finally the mucous membrane was brought together. There was very little bleeding. The patient's bed was raised by placing the foot on two chairs. The plug and tube were removed two hours later. There was present a slight recurrence in the scar and an enlarged gland.

The PRESIDENT congratulated Dr. Peters upon the clean sweep which he had made so far. He thought some further operation was justified. The inability to open the mouth he regarded as a result of the scar. He recommended a freer operation in the sub-maxillary and cervical regions, which, combined with a further removal of the growth in the mouth, offered good prospects.

Mr. BETHAM ROBINSON suggested that Dr. Peters should divide the jaw, by which he would not only secure good mobility, but would get satisfactorily at the ulcer.

FUNCTIONAL APHONIA IN A SOLDIER AFTER AGUE.

Shown by Dr. E. A. PETERS. The patient, aged twenty-five, lately in the 13th Hussars, was in the South African campaign for two years, with only one month in hospital.

On February 19, 1905, while in India he was thrown from a horse and one month later was admitted for a severe attack of "ague" which lasted about fourteen days; an attack of convulsions resulted in complete paralysis of all the limbs without bladder trouble. Aphonia set in at the same time.

In March, 1906, on examination there was complete aphonia. The pharynx and larynx were nearly insensitive. On attempted phonation the vocal processes flicked together, but the cords were lax. During respiration the cords were widely abducted, while there was only a suspicion of movement.

In May the patient twisted his ankle and recovered his voice.

CHRONIC OSTEITIS OF THE FRONTAL BONE WITH CHRONIC SINUSITIS.

Shown by Dr. E. A. PETERS. The patient was a road-sweeper aged forty-one. Three years ago a radical cure of the left maxillary antrum was carried out, with removal of the outer wall of the inferior meatus for chronic empyema. Extensive pyorrhœa alveolaris was present; this had never subsided.

In January, 1905, he suffered with headache, and an abscess presented beneath the right supra-orbital margin. This remained open.

In June, 1905, he came to hospital. There was a little pus in either side of the nose, but no collection in the left antrum.

Dr. Peters explored the right frontal sinus region, but could find no sinus or infundibulum. He scraped a considerable amount of softened diploe away at this spot and also beneath the suppurating abscess tract.

In May, 1905, there was pus in both sides of the nose and a

probe did not pass above the orbital margin on the right side. On the left side a probe entered into a large frontal sinus which was full of pus. There was no external swelling or pain.

The PRESIDENT said the patient seemed to have suppuration on both sides of the nose, and he thought there must be a frontal sinus somewhere on the right side, possibly small, and a fairly large one on the left.

Dr. STCLAIRE THOMSON said he had a very similar case to the present one, which gave him a good deal of trouble. The patient had chronic sinusitis in most of the cavities of the head, and evidently had had an acute attack, with swelling over the right orbit. This was lanced in the country, ran an indefinite course, and came with a sinus similar to that in Dr. Peters' case, but farther out. The frontal sinus was full of pus and polypi, but it did not communicate with the fistula in question; it was a fronto-ethmoidal gallery, which ran out over the top of the orbit. He thought the present case was one of suppuration of one of the accessory cavities, probably the frontal, and of the ethmoidal cells. He had already suggested to Dr. Peters that if he did practically a Killian flap—making the flap from the middle line on to and below the inner canthus—he would get freely into the ethmoidal cavity, and would no doubt reach the bottom of the suppuration. His own case would be published next month, with photographs. It gave him much trouble because he had not at first been bold enough. His patient got well.

FIXATION OF THE LEFT VOCAL CORD IN THE CADAVERIC POSITION, MOST PROBABLY DUE TO ADHESIONS FIXING AND DRAGGING ON THE RECURRENT LARYNGEAL NERVE.

Shown by Mr. STUART LOW. He had shown this case as the condition, especially in a young woman, was uncommon, and the cause unusual. The patient was a young woman aged nineteen, and she came to the Central London Throat and Ear Hospital complaining of failure of the voice on speaking for any length of time. This had been present for six months. She had been under her doctor, but had not benefited by the treatment.

There was a history of severe rheumatic fever eight years ago, and she had had at intervals since repeated recurrences of rheumatic pains in her joints.

Examination of the larynx showed the left vocal cord completely fixed in the cadaveric position. The opposite cord came over and approximated well to the left vocal cord on phonation. The voice was of pure, low-pitched tone and there was no intermittent hoarseness.

Examination of the chest revealed the following: There was mitral regurgitation and considerable enlargement of both right and left ventricles. This, however, probably did not in itself account for the very great cardiac enlargement. On the other

hand, pericarditis leading to adhesions was a frequent complication of rheumatic endocarditis in childhood and was a recognised explanation of some of the marked cardiac enlargements which are met with in early life. The probability therefore was that a condition of pericardial adhesion was present.

Pericarditis was mentioned by several writers as a cause of laryngeal paralysis. There was presumptive evidence of pericardial adhesions. Such adhesions may be responsible for a laryngeal paralysis. Therefore in all probability the paralysis present in this case was the result of pericardial inflammation and consequent thickening and adhesions to the neighbourhood of the recurrent laryngeal nerve as this looped backward under the aortic arch.

Dr. H. J. DAVIS said he thought Dr. Atwood Thorne last year showed a case of the same kind, and it was thought to be probably due to left auricular dilatation. The skiagram now shown was suggestive of a dilated left auricle pressing on the recurrent laryngeal nerve. Adhesions forming in the pericardium in pericarditis was common, but he did not remember to have seen a case where the adhesion was said to have dragged on the recurrent laryngeal nerve and caused paralysis. He thought the present patient was more likely to have a dilated left auricle as a result of mitral disease with consequent regurgitation. She was able to talk well, and the right cord swung over to meet its fellow. There was no dilatation of pupil on either side, as was present in Dr. Atwood Thorne's case. In a severe attack of pericarditis there was myocarditis and endocarditis as well, for there was only the thickness of the myocardium for the inflammation to spread through.

Mr. BARWELL said that a dilated left auricle was commonly given as a cause of paralysis of the recurrent laryngeal nerve; but he had not heard adhesions mentioned before. He believed cases had been reported in which the nerve had been compressed by massive pericardial effusion. A similar case was recorded in the *Archives Internationales*, in which paralysis of the recurrent laryngeal on the left side followed a right pneumothorax. In that case the suggestion made was that there was positive pressure in the right pleura, which pushed over the arch of the aorta and dragged on the recurrent laryngeal. Therefore apparently various changes in the chest might give rise to that paralysis, and it became a matter of conjecture as to which was operating in a given case.

Mr. STUART Low, in reply, said it was considered doubtful whether the shadow in the skiagram represented the left auricle. Physicians said they could not depend on it. There was dragging on the chest-wall, which was thought to be due to pericardial adhesions; if the patient had been stripped and lying on a couch, that dragging would have been very obvious. Moreover, the distress of the patient on exertion was far more than would be accounted for by hypertrophy of the organ. The hypertrophy of the heart was thought to be due to the effort of that organ to overcome the adhesions.

ANNUAL GENERAL MEETING, *June 1, 1906.*

CHARTERS J. SYMONDS, F.R.C.S., President, in the Chair.

The minutes of the last Annual General Meeting, held on January 12, 1906, were read and confirmed.

Mr. Stuart Low and Mr. Harold Barwell were appointed scrutineers of the ballot. The following were elected Officers and Members of the Council for the ensuing year:

President—J. B. Ball, M.D.

Vice-Presidents—F. Willcocks, M.D., Charters J. Symonds, F.R.C.S., William Hill, M.D., P. Watson-Williams, M.D.

Hon. Treasurer—H. B. Robinson, F.R.C.S.

Hon. Librarian—StClair Thomson, M.D.

Hon. Secretaries—H. J. Davis, M.B., W. Jobson Horne, M.D.

Council—Sir Felix Semon, K.C.V.O., M.D., Philip de Santi, F.R.C.S., J. Middlemass Hunt, M.B., S. Paget, F.R.C.S., Atwood Thorne, M.B.

Mr. H. B. Robinson submitted the Treasurer's Report and Balance Sheet, which were read and unanimously adopted.

BALANCE SHEET, SESSION 1905-1906.

INCOME.			EXPENDITURE.		
	£	s. d.		£	s. d.
Balance, January, 1906	1	14 0	Rent	21	0 0
Subscriptions	118	13 0	Expenses of Amalgamation		
Entrance Fees	3	3 0	Scheme	3	0 5
Interest on Deposit	1	7 6	Adlard—Printing	12	3 6
			Baker—Microscopes	0	5 1
			Creswick—Receipt Book	0	7 6
			Martindale	0	13 3
			Porters' Christmas Boxes	1	0 0
			Bank Charges	0	0 9
			Secretaries' Expenses	1	12 11
			Treasurer's „	0	15 11
				40	19 4
			Balance	83	18 2
	£124	17 6		£124	17 6

Deposit at Banker's (London Joint Stock Bank)—£150.

Examined vouchers and found correct.

H. FITZGERALD POWELL, } *Auditors.*
ATWOOD THORNE, }

June 1, 1906.

HY. BETHAM ROBINSON, *Hon. Treasurer.*

INDEX.

	PAGE
Adhesions fixing and dragging on recurrent laryngeal nerve most probable cause of case of fixation of left vocal cord in cadaveric position (W. Stuart-Low)	113
Ague, functional aphonia following (E. A. Peters)	112
Amalgamation of medical societies: special general meeting held to consider Report of Council <i>re</i> union of medical societies	28
Angeo-fibroma, microscopic section of (E. A. Peters)	40
Angeioma (nasal) (bleeding polypus) removed from floor of inferior meatus (W. H. Kelson)	72
Annual General Meeting (fourteenth), held January 12th, 1906	27
————— (fifteenth), June 1st, 1906	115
Antrum (maxillary), malignant disease of (J. Dundas Grant)	1
Aphonia (functional) after ague (E. A. Peters)	112
Arytenoid (right) fixation of, case for diagnosis (E. F. Potter)	88
———— fold, tumour of, probably tuberculous (Sir Felix Semon)	10
———— region, large sessile tumour in (H. W. Carson)	88
Auricles, indurated swelling of both auricles in case of swelling below anterior commissure of vocal cords (C. A. Parker)	100
BABER (E. Cresswell), discussion on specimen of rhinolith	16
———— discussion on sudden loss of voice	75
———— discussion on nasal obstruction	76
———— discussion on absence of right choana	77
———— discussion on malignant growth in naso-pharynx	86
———— discussion on swelling of upper part of septum nasi; for diagnosis	89
———— discussion on case of infiltration of the left vocal cord	110
Bacterial vaccine: see <i>Vaccine</i> (bacterial)	
Balance sheet, 1905	28
———— (1905-6)	115
BALDWIN (Aslett), discussion on three cases of syphilis in one family	92
BALL (J. B.), case of ulceration of the pharynx and larynx	39
Discussion (p. 40). Mr. Robinson, Mr. Symonds (President), Dr. Smurthwaite, Dr. Ball (reply).	
———— discussion on suppuration of frontal sinuses, treated by intra-nasal methods	37
BARWELL (Harold S.), case of tuberculous ulceration of the nose, healed under treatment	17
Discussion (pp. 17, 18). Dr. StClair Thomson, Dr. Watson Williams, Dr. Jobson Horne, Mr. Barwell (reply).	
———— case of lupus of larynx and uvula, healed under treatment	18
Discussion (pp. 18, 19). Dr. StClair Thomson, Dr. Jobson Horne.	
———— case of tuberculous laryngitis; removal of epiglottis, cure	59
———— tuberculous laryngitis; active local treatment; cure	60
Discussion (pp. 60-62). Mr. Waggett, Dr. Davis, Dr. Westmacott, Dr. Watson Williams, Dr. Horne, Mr. Barwell (reply).	

	PAGE
BARWELL (Harold S.), case of ulceration of epiglottis	62
Discussion (pp. 62, 63). Dr. Davis, Dr. Watson Williams, Mr. Barwell (reply).	
— a case of infiltration of the left vocal cord	110
Discussion (p. 110). Mr. Cresswell Baber, Dr. StClair Thomson, Mr. Barwell (reply).	
— discussion on immobile left cord	5
— discussion on case of chronic thickening and deformity of epiglottis for diagnosis	11
— discussion on left recurrent paralysis and paralysis of soft palate associated with middle-ear disease and facial palsy	94
— discussion on tuberculosis of soft palate, pharynx, and epiglottis	100
— discussion on case of fixation of left vocal cord in cadaveric position	115
BENNETT (F. W.), discussion on suppuration of frontal sinuses treated by irrigation only	49
BOND (J. W.), a case of palatal tumour of twenty years' duration	111
Discussion (p. 111). Mr. C. J. Symonds (President).	
Bougies, dilatation of infundibulum by means of (J. Dundas Grant)	36, 46
BRONNER (Adolph), discussion on ulceration of left vocal cord	39
BUTLIN (H. T.), discussion on swelling below anterior commissure of vocal cords, causing dyspnoea, with deformity of epiglottis and indurated swelling of both auricles	101
— discussion on case of villous papillomatous growth in larynx, probably epithelioma	102
Cadaveric position, fixation of left vocal cord in (W. Stuart-Low)	113
Calomel injections in treatment of extensive syphilitic ulceration (J. Dundas Grant)	44
Cancer (inoperable) of fauces, pharynx, tongue, and cervical glands, treated with bacterial vaccine of <i>neoformans</i> ; marked amelioration (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
Cannula (tracheal), worn for incomplete bilateral paralysis of posterior crico-arytenoid muscles for twenty-seven years (Sir F. Semon)	32
Carcinoma of naso-pharynx (C. J. Symonds)	87
CARSON (H. W.), a man with an ulcerated swelling in the middle line of naso-pharynx and ulceration of left posterior fold of the palate	88
Discussion (p. 88). Dr. J. Dundas Grant.	
— a woman with large sessile tumour in left arytenoid region	88
Discussion (p. 88). Dr. Hill, Dr. Spicer, Mr. Symonds, Mr. de Santi, Mr. Carson (reply)	
CATHCART (G. C.), case of tertiary syphilis of the larynx	24
Discussion (p. 24). Mr. de Santi.	
— report on the autopsy of case of incrustations in the trachea shown by Dr. E. Law	25
Centenary of Señor Manuel Garcia	27
Cervical glands: cancer (inoperable) of fauces, pharynx, tongue, and cervical glands treated with bacterial vaccine of <i>neoformans</i> (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
Chin, sinus of (W. H. Ke'son)	32
Choana (right), absence of (E. B. Waggett).	71, 76
Council, Report of, for year ending January 12th, 1906	27
Crico-arytenoid joint (right), fixation of, due to infiltration, probably malignant (E. F. Potter)	49
— muscles, incomplete bilateral paralysis of; tracheal cannula worn for, during twenty-seven years (Sir F. Semon)	32
Curator of Pathological Collection, report of (1905)	30
Cyst: pedunculated tumour, probably cystic, growing from the supra-tonsillar fossa (J. Dundas Grant)	3
— of right ventricular band (A. Logan Turner)	85

	PAGE
DAVIS (H. J.), a case of atrophic rhinitis	63
Discussion (p. 63). Drs. Davis, Smurthwaite, Watson, Mr. C. Parker.	
— a case of sudden loss of voice	75
Discussion (pp. 75, 76). Messrs. Baber, Thorne; Drs. Grant, StClair Thomson; Mr. Symonds, (President) Dr. Davis (reply).	
— a case of nasal obstruction	76
Discussion (p. 76). Mr. Baber, Dr. Hill.	
— three cases of syphilis in one family, (?) communicated by oral infection from one to the other, with photograph	91
Discussion (pp. 92, 93). Mr. C. J. Symonds (President), Dr. J. Donelan, Mr. Aslett Baldwin, Dr. Davis (reply).	
— discussion on chronic pharyngitis with polypi of uvula	22
— discussion on laryngeal ulceration	43
— discussion on extensive syphilitic ulceration in pharynx treated by calomel injections	45
— discussion on tuberculous laryngitis	60
— discussion on absence of right choana	71, 78
— discussion on ulceration of left cord	79
— discussion on case of fixation of right arytenoid, for diagnosis	88
— discussion on growth on left side of child's tongue	89
— discussion on swelling below anterior commissure of vocal cords, causing dyspnoea, with deformity of epiglottis and indurated swelling of both auricles	101
— discussion on case of fixation of left vocal cord in cadaveric position	114
Deformity (nasal), injection of cold paraffin for (J. Dundas Grant)	53
Denture impacted in gullet, œsophagotomy performed for removal of (W. Downie)	67
Diagnosis, cases for: fixation of right arytenoid (E. F. Potter)	88
— malignant disease of maxillary antrum (J. Dundas Grant).	1
— swelling on upper part of nasal septum (J. Donelan)	89
— thickening of right cord, thought to be malignant (H. Smurthwaite)	69
Diaphragm of dense fibrous tissue shutting off pharynx from naso-pharynx with exception of small aperture (A. Logan Turner)	85
Diverticulum of œsophagus (J. Dundas Grant)	4
DONELAN (James), chronic thickening and deformity of epiglottis and vocal cords of four years' duration in a girl aged sixteen, for diagnosis	11
Discussion (p. 11). Dr. Vinrace, Mr. Barwell, Dr. Pegler, Dr. Watson Williams, Dr. Donelan (reply).	
— case of laryngeal ulceration in a man aged fifty-four	43
Discussion (pp. 43, 44). Mr. Parker, Dr. Davis, Mr. Symonds (President), Dr. Donelan (reply).	
— a woman, aged twenty-four, with a swelling on the upper part of the septum nasi, for diagnosis	89
Discussion (p. 89). Mr. Baber.	
— discussion on Eustachian cartilages, projecting into naso-pharynx, preventing free nasal breathing	6
— discussion on injection of cold paraffin for nasal deformity	55
— discussion on absence of right choana	77
— discussion on three cases of syphilis in one family	92
— discussion on left recurrent paralysis and paralysis of soft palate, associated with middle-ear disease and facial palsy	95
DOWNIE (Walker), recent photographs of some cases of paraffin injection for nasal deformity, as well as others taken immediately after treatment four years ago	64
Discussion (pp. 66, 67). Dr. Watson Williams, Mr. Paget, Mr. Parker, Drs. Spicer, Smurthwaite, Mr. De Santi, Dr. Downie (reply).	

	PAGE
DOWNIE (Walker), description of two cases where œsophagotomy was performed for the removal of a denture impacted in the gullet	67
Dyspnœa, caused by swelling below anterior commissure of vocal cords (C. A. Parker)	100
Ear (middle), disease of, and facial palsy associated with left recurrent paralysis and paralysis of soft palate (D. R. Paterson)	94
Empyema of right frontal sinus, in subacute osteomyelitis of frontal bone (R. H. Scanes Spicer)	13
Empyemata of frontal sinus, chronic, operated on by a simplified Killian operation (H. Tilley)	96
Epiglottis and base of tongue, malignant disease of (P. R. W. de Santi)	7
— chronic thickening and deformity of; case for diagnosis (J. Donelan)	11
— deformity of, in case of swelling below anterior commissure of vocal cords (C. A. Parker)	100
— removal of, in tuberculous laryngitis (H. Barwell)	59
— tuberculosis of soft palate, pharynx, and epiglottis (C. Fox)	98
— ulceration of (H. Barwell)	62
Epithelioma of naso-pharynx (W. Stuart-Low)	51
— of palate (J. Dundas Grant)	103
— of tonsils, case of (E. A. Peters)	111
— villous papillomatous growth in larynx, probably epithelioma (J. Dundas Grant)	101
— — — — — preparations illustrating, shown by Dr. Wyatt Wingrave	102
Eustachian cartilages (abnormally large) projecting into naso-pharynx, preventing free nasal breathing (E. Furniss Potter)	5
Excrescences in interarytenoid space: a point in differential diagnosis of (W. Jobson Horne)	12
Fauces: cancer (inoperable) of fauces, pharynx, tongue, and cervical glands, treated with bacterial vaccine of <i>neoformans</i> (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
Fibro-angioma of nasal septum (H. B. Robinson)	68
Fibroma of larynx, specimen (A. Logan Turner)	84
Fibrous tissue diaphragm shutting off pharynx from naso-pharynx with exception of small aperture (A. Logan Turner)	85
Fish-hook removed from œsophagus (D. R. Paterson)	93
Fixation of right arytenoid, case for diagnosis (E. F. Potter)	88
— of left vocal cord in cadaveric position (W. Stuart-Low)	113
— of right vocal cord, with infiltration (J. Dundas Grant)	89
Fox (Clayton), a case of tuberculosis of the soft palate, the pharynx, and the epiglottis	98
— Discussion (p. 100). Mr. Barwell, Mr. Clayton Fox (reply).	
— discussion on left recurrent paralysis and paralysis of soft palate, associated with middle-ear disease and facial palsy	95
Frontal bone: chronic osteitis of, with chronic sinusitis (E. A. Peters)	112
— subacute osteomyelitis of, with empyema of right frontal sinus (R. H. Scanes Spicer)	13
Frontal sinus: empyemata of (chronic), operated on by a simplified Killian operation (H. Tilley)	96
— (left) suppuration of, and of left maxillary sinus, closure of wound and irrigation (C. J. Symonds)	56
— (right) empyema of, in subacute osteomyelitis of frontal bone (R. H. Scanes Spicer)	13
Frontal sinuses, suppuration in, treated by intra-nasal methods, including dilatation of the infundibulum by means of bougies (J. Dundas Grant)	36, 46
— — — — — treated by irrigation only (C. J. Symonds)	46

	PAGE
Garcia, Señor Manuel: celebration by the Society of his centenary . . .	27
Glottis (stenosis of) (StClair Thomson) . . .	80
Granulomata (syphilitic) and stenosis of the larynx; thyrotomy performed (P. R. W. de Santi) . . .	19
GRANT (J. Dundas), case for diagnosis, probably malignant disease of the maxillary antrum . . .	1
Discussion (pp. 2, 3). The President (Mr. C. J. Symonds), Dr. Pegler, Dr. Scanes Spicer. . .	
— case of traumatic lesion of larynx . . .	3
— case of a pedunculated tumour, probably cystic, growing from the supra-tonsillar fossa . . .	3
Discussion (p. 3). Dr. Jobson Horne. . .	
— case of diverticulum of the œsophagus . . .	4
— case of swelling over the left superior maxilla in a middle-aged woman . . .	23
Discussion (pp. 23, 24). Mr. de Santi, Dr. Pegler, Mr. Waggett, Dr. Westmacott, Dr. Grant (reply). . .	
— case of ulceration of the pharynx (probably specific) presenting unusual features . . .	33
Discussion (pp. 34-36). Sir F. Semon, Dr. McBride, Dr. Lieven, Mr. Symonds (President), Dr. Grant (reply). . .	
— case of suppuration in both frontal sinuses treated by intra-nasal methods, including dilatation of the infundibulum by means of bougies (with skiagram) . . .	36, 46
Discussion (pp. 36-38). Dr. Pegler, Mr. Tilley, the President (Mr. C. J. Symonds), Sir F. Semon, Dr. J. B. Ball, Dr. Grant (reply). . .	
— case of extensive syphilitic ulceration in the pharynx of a man aged twenty-eight, treated by calomel injections; illustrating rapid improvement in the patient . . .	44
Discussion (pp. 44, 45). Mr. Symonds, Dr. Kelson, Mr. Parker, Dr. Davis, Dr. Grant (reply). . .	
— Sondermann's suction apparatus . . .	45
— case of injection of cold paraffin for nasal deformity . . .	53
Discussion (pp. 54-56). Sir F. Semon, Dr. Donelan, Dr. Spicer, Dr. Vinrace, Dr. Grant (reply). . .	
— case of infiltration, with fixation, of the right vocal cord in a man aged forty-six . . .	89
Discussion (p. 90). Mr. Symonds (President), Dr. StClair Thomson, Mr. Atwood Thorne, Dr. Grant (reply). . .	
— villous papillomatous growth, probably epithelioma (but with doubtful histological characters; a history of old specific infection; anti-specific remedies not yet tried) in a man aged forty-six: see also <i>Wingrave</i> (V. Wyatt), preparations illustrating, etc. . .	101
— case of epithelioma of the palate in a male patient aged sixty . . .	103
Discussion (p. 103). Mr. Robinson, Dr. StClair Thomson, Mr. Symonds (President). . .	
— discussion on immobile left cord . . .	4
— discussion on sarcomatous growth of left nasal cavity . . .	10
— discussion on a case of tumour in interarytenoid fold, probably tuberculous . . .	11
— discussion on multiple papilloma of larynx recurring after fifteen years . . .	13
— discussion on sclerotic hyperplasia of pharynx and naso-pharynx . . .	21
— discussion on chronic pharyngitis with polypi of uvula . . .	22
— discussion on angeio-fibroma . . .	41
— discussion on suppuration of frontal sinuses treated by irrigation only . . .	49
— discussion on fixation of right crico-arytenoid joint due to infiltration, probably malignant . . .	50
— discussion on intrinsic laryngeal neoplasm . . .	51

	PAGE
GRANT (J. Dundas), discussion on sudden loss of voice	76
—— discussion on absence of right choana	77
—— discussion on ulceration of left cord	79
—— discussion on glottic stenosis	81
—— discussion on carcinoma of naso-pharynx	87
—— discussion on ulcerated swelling in middle line of naso-pharynx, and ulceration of left posterior fold of palate	88
—— discussion on left recurrent paralysis and paralysis of soft palate associated with middle-ear disease and facial palsy	94
—— discussion on bilateral ulceration of posterior segments of vocal cords	95
—— discussion on chronic frontal empyemata operated on by simpli- fied Killian operation	96
Growth (papillary) on left side of tongue (P. R. W. de Santi)	89
—— (pedunculated) of uvula (W. H. Kelson)	51
Gullet: see <i>Œsophagus</i> .	
HALL (F. de Havilland), discussion on immobile left cord	4
—— discussion on perverted action of the cords	9
—— discussion on a case of tumour in interarytenoid fold, probably tuberculous	11
HILL (William), recent nasal polypus and sinusitis in a patient with long-standing atrophic rhinitis	24
Discussion (p. 24). Dr. Watson Williams, Mr. Waggett, Mr. Stuart- Low.	
—— discussion on Eustachian cartilages, projecting into naso-pharynx, preventing free nasal breathing	6
—— discussion on nasal obstruction	76
—— discussion on absence of right choana	77
—— discussion on large sessile tumour in left arytenoid region	88
—— discussion on left recurrent paralysis and paralysis of soft palate associated with middle-ear disease and facial palsy	95
HORNE (W. Jobson), a point in the differential diagnosis of excrescences in the interarytenoid space	12
—— pathological report of autopsy of case of incrustations in trachea, shown by Dr. E. Law	26
—— discussion on pedunculated tumour, probably cystic, growing from the supra-tonsillar fossa	3
—— discussion on perverted action of the cords	9
—— discussion on multiple papilloma of larynx recurring after fifteen years	13
—— discussion on specimen of rhinolith	16
—— discussion on lupus of larynx and uvula, healed under treatment	18
—— discussion on tuberculous ulceration of nose, healed under treat- ment	18
—— discussion on angeio-fibroma	41
—— discussion on tuberculous laryngitis	61
Hyperplasia (sclerotic) of pharynx and naso-pharynx (A. Brown Kelly)	20
Incrustations of trachea, reports of fatal termination of case (Drs. Law, Cathcart, Jobson Horne)	25, 26
Infection, oral: question of communication of three cases from one to the other of syphilis in one family by (H. J. Davis)	91
Infiltration of left vocal cord (H. S. Barwell)	110
—— with fixation, of right vocal cord (J. Dundas Grant)	89
Infundibulum, dilatation of, by means of bougies, intra-nasal method of treating suppuration of frontal sinuses (J. Dundas Grant)	36, 46
Instruments for submucous resection operation (H. Smurthwaite)	79
Interarytenoid space, a point in the differential diagnosis of excrescences in (W. Jobson Horne)	12

	PAGE
Intra-nasal methods in treatment of suppuration in both frontal sinuses (Dundas Grant)	36
Irrigation only treatment in case of suppuration of frontal sinuses (C. J. Symonds)	46
—— after closure of wound in treatment of suppuration of frontal and maxillary sinuses (C. J. Symonds)	56
KELLY (A. Brown), sclerotic hyperplasia of the pharynx and naso-pharynx	20
Discussion (pp. 21, 22). Dr. J. Dundas Grant, Dr. Pegler, Dr. Smurthwaite, Dr. Brown Kelly (reply).	
—— Two beautiful sketches of multiple telangiectasis of the skin and mucous membrane of the nose and mouth	22
—— sketch of larynx and microscopic section of uvula from case of hyperplastic congenital syphilis	68
KELSON (W. H.), immobile left cord in a lad aged seventeen	4
Discussion (pp. 4, 5). Dr. de Havilland Hall, Dr. Dundas Grant, Mr. Barwell, Sir Felix Semon, Dr. Fitzgerald Powell, Dr. Kelson, (reply).	
—— a case of sinus of the chin	32
Discussion (p. 32). Mr. Betham Robinson, the President (Mr. C. J. Symonds).	
—— a case of ulceration of the left vocal cord	38, 39
Discussion (pp. 38, 39). Dr. McBride, Sir Felix Semon, Dr. Bronner, Dr. Smurthwaite, Dr. Kelson (reply).	
—— a pedunculated growth of uvula in a boy aged nineteen	51
Discussion (p. 51). The President (Mr. Symonds), Sir Felix Semon.	
—— a case of ulceration of left cord	79
Discussion (p. 79). Drs. Dundas Grant, Scanes Spicer, Mr. Symonds, Dr. Davis, Dr. Kelson (reply).	
—— microscopic section from a case of nasal angioma (bleeding polypus) removed from the floor of the inferior meatus in a girl aged fifteen. Shown by Dr. Pegler	72
—— discussion on extensive syphilitic ulceration in pharynx, treated by calomel injections	44
Keratosis of larynx : specimen (A. Logan Turner)	82
Killian's operation, simplified form, used in four cases of chronic frontal empyemata (H. Tilley)	96
KIRSCHNER (L.), quotation of his remarks on use of paraffin injections, by Sir Felix Semon	54
LACK (H. Lambert) discussion on malignant disease of base of tongue and epiglottis	8
—— discussion on absence of right choana	77
Laryngitis (tuberculous), active local treatment; cure (H. Barwell)	60
—— removal of epiglottis for (H. S. Barwell)	59
Larynx, fibroma of, specimen (A. Logan Turner)	84
—— intrinsic neoplasm of (R. H. Scanes Spicer)	50
—— keratosis of; specimen (A. Logan Turner)	82
—— pachydermia of; specimen (A. Logan Turner)	83
—— papilloma of, diffuse; specimen (A. Logan Turner)	83
—— (multiple) recurring after fifteen years (R. H. Scanes Spicer)	12
—— sketch of, from case of hyperplastic congenital syphilis (A. Brown Kelly)	68
—— specimen from case of sudden death (A. Logan Turner)	81
—— syphilis of, tertiary (G. C. Cathcart)	24
—— traumatic lesion of (Dundas Grant)	3
—— ulceration of (J. Donelan)	43
—— villous papillomatous growth in, probably epithelioma (J. Dundas Grant)	101
—— ——— preparations illustrating, shown by Dr. Wyatt Wingrave	102

	PAGE
Larynx and pharynx, ulceration of (J. B. Ball)	39
—— and uvula, lupus of, healed under treatment (H. S. Barwell)	18
LAW (Edward), report on the fatal termination of the case of incrustations in the trachea shown on November 4 and December 2, 1904	25
Report of autopsy (p. 25). Microscopical report (p. 26).	
Librarian (Honorary) Report of, for year 1905	29
LIEVEN (Dr.), discussion on ulceration of pharynx, probably specific	35
Lupus of larynx and uvula, healed under treatment (H. S. Barwell)	18
McBRIDE (Peter), discussion on ulceration of pharynx, probably specific	35
—— discussion on ulceration of left vocal cord	38
Malignant disease of base of tongue and epiglottis (P. R. W. de Santi)	7
—— of maxillary antrum (J. Dundas Grant)	1
—— probable, in fixation of right crico-arytenoid joint, due to infiltration (E. F. Potter)	49
—— growth in naso-pharynx, question of operation (P. R. W. de Santi)	86
—— thickening of right vocal cord (H. Smurthwaite)	69
Maxilla (left superior), swelling over (J. Dundas Grant)	23
Maxillary sinuses (left), suppuration of, and of left frontal sinus (C. J. Symonds)	56
Meat, piece of, impacted in stricture of gullet (D. R. Paterson)	93
Meatus (inferior), nasal angioma removed from (W. H. Kelson)	72
Meetings: see <i>Annual General Meeting</i> , <i>Special General Meeting</i> .	
<i>Micrococcus neoformans</i> , bacterial vaccine of, in treatment of case of inoperable cancer of fauces, pharynx, tongue, and cervical glands; marked amelioration (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
Morbid Growths Committee, Report of	15, 105
Mouth and nose, multiple telangiectasis of skin and mucous membrane of; two sketches shown by Dr. Brown Kelly	22
Mycosis of soft palate (H. Tilley)	103
Nasal obstruction (H. J. Davis)	76
—— saw (new) (E. A. Peters)	96
Naso-pharynx: abnormally large Eustachian cartilages projecting into naso-pharynx, preventing free nasal breathing (E. Furniss Potter)	5
—— carcinoma of (C. J. Symonds)	87
—— epithelioma of (W. Stuart-Low)	51
—— malignant growth in; question of operation (P. R. W. de Santi)	86
—— shut off from pharynx by fibrous tissue diaphragm (A. Logan Turner)	85
—— tumour, lobulated, encapsuled, attached to posterior wall of naso-pharynx; clinically, simple tumour, microscopically, sarcoma (A. Logan Turner)	84
—— ulcerated swelling in middle line of (H. W. Carson)	88
—— and pharynx, sclerotic hyperplasia of pharynx and naso-pharynx (A. Brown Kelly)	20
Neck, skiagram of, in case with piece of meat impacted in stricture of gullet (D. R. Paterson)	93
Neoplasm (intrinsic laryngeal) (R. H. Scanes Spicer)	50
Nerve (recurrent laryngeal), adhesions fixing and dragging on, most probable cause of case of fixation of left vocal cord in cadaveric position (W. Stuart-Low)	113
—— (left recurrent laryngeal), paralysis of, with paralysis of soft palate associated with middle-ear disease and facial palsy on same side (D. R. Paterson)	94
Nose (deformities of), paraffin injection for; photographs of (W. Downie)	64
—— (diseases), specimens and drawings illustrating various pathological conditions (A. Logan Turner)	81

	PAGE
Nose: multiple telangiectasis of skin and mucous membrane of nose and mouth; sketches shown by Dr. Brown Kelly	22
—— septum of. See <i>Septum</i> (nasal).	
—— tuberculous ulceration of, healed under treatment (H. S. Barwell)	17
—— sarcomatous growth of left nasal cavity (P. R. W. de Santi)	9
NOURSE (W. Chichele), discussion on suppuration of frontal sinuses treated by irrigation only	48
Œsophagotomy performed for removal of denture impacted in gullet (W. Downie)	67
Œsophagus, diverticulum of (J. Dundas Grant)	4
—— fish-hook removed from (D. R. Paterson)	93
—— stricture of, piece of meat impacted in (D. R. Paterson)	93
—— tooth-plate removed from (D. R. Paterson)	93
Officers, election of, for session 1906	27
—— for session 1906-7	115
Oral infection: question of communication of three cases from one to the others of syphilis in one family (H. J. Davis)	91
Osteitis (chronic), of frontal bone, with chronic sinusitis (E. A. Peters)	112
Osteomyelitis (subacute) of frontal bone, with empyema of right frontal sinus (R. H. Scanes Spicer)	13
Pachydermia of larynx; specimen (A Logan Turner)	83
PAGET (Stephen), discussion on paraffin injection for nasal deformity	66
Palate, epithelioma of (J. Dundas Grant)	103
—— (tumour of), twenty years' duration (J. W. Bond)	111
—— ulceration of left posterior fold of (H. W. Carson)	88
—— (soft), mycosis of (H. Tilley)	103
—— paralysis of, with left recurrent paralysis, associated with middle-ear disease and facial palsy on same side (D. R. Paterson)	94
—— tuberculosis of soft palate, pharynx, and epiglottis (C. Fox)	98
—— ulceration and destruction of, with posterior pharyngeal wall (A. Logan Turner)	85
Palsy (facial) and middle-ear disease associated with left recurrent paralysis and paralysis of soft palate (D. R. Paterson)	94
Papillary growth on left side of tongue of child (P. R. W. de Santi)	89
Papilloma (diffuse) of larynx; specimen (A. Logan Turner)	83
—— (multiple) of larynx recurring after fifteen years (R. H. Scanes Spicer)	12
Papillomatous growth, villous, in larynx, probably epithelioma (J. Dundas Grant)	101
—— preparations illustrating, shown by Dr. Wyatt Wingrave	102
Paraffin injection for nasal deformity, photographs of (W. Downie)	64
—— (cold), injection of, for nasal deformity (J. Dundas Grant)	53
Paralysis (incomplete bilateral) of crico-arytenoid muscles, tracheal cannula worn for, during twenty-seven years (Sir F. Semon)	32
—— of left recurrent nerve and paralysis of soft palate, with middle-ear disease and facial palsy on same side (D. R. Paterson)	94
PARKER (Charles A.), a case of swelling below the anterior commissure of the vocal cords, causing some dyspnoea, with deformity of the epiglottis and indurated swelling of both auricles in a woman aged fifty-five	100
—— Discussion (p. 101). Mr. Butlin, Dr. Davis	
—— discussion on laryngeal ulceration	43
—— discussion on extensive syphilitic ulceration in pharynx, treated by calomel injections	45
—— discussion on case of atrophic rhinitis	63
—— discussion on paraffin injection for nasal deformity	66
PATERSON (D. R.), fish-hook removed from the œsophagus	93

	PAGE
PATERSON (D. R.), skiagram of the neck in a case where a piece of meat was impacted in a stricture of the gullet	93
—— tooth-plate removed from the œsophagus	93
—— left recurrent paralysis and paralysis of the soft palate associated with middle-ear disease and facial palsy on the same side	94
Discussion (pp. 94, 95). Dr. Dundas Grant, Mr. Barwell, Dr. StClair Thomson, Dr. Donelan, Mr. Clayton Fox, Dr. W. Hill, Mr. C. J. Symonds (President), Dr. Paterson (reply).	
Pathological Collection, report of Curator (1905)	30
Pedunculated growth of uvula (W. H. Kelson)	51
PEGLER (L. Hemington), Report of Curator of Pathological Collection (1905)	30
—— case of secondary syphilitic lesions of the vocal cords in a girl aged twenty	
—— microscopic section from a case of nasal angeioma (bleeding polypus) removed from the floor of the inferior meatus in a girl aged fifteen by Dr. Kelson	72
—— bilateral ulceration of the posterior segments of the vocal cords in a man	95
Discussion (pp. 95, 96). Dr. Grant, Mr. Symonds (President), Dr. Pegler (reply).	
—— discussion on malignant disease of maxillary antrum	3
—— discussion on Eustachian cartilages, projecting into naso-pharynx, preventing free nasal breathing	6
—— discussion on sarcomatous growth of left nasal cavity	10
—— discussion on case of chronic thickening and deformity of epiglottis for diagnosis	11
—— discussion on sclerotic hyperplasia of pharynx and naso-pharynx	21
—— discussion on chronic pharyngitis with polypi of uvula	23
—— discussion on swelling over left superior maxilla	23
—— discussion on suppuration of frontal sinuses treated by intra-nasal methods	36, 37
—— discussion on angeio-fibroma	40, 41
—— discussion on intrinsic laryngeal neoplasm	51
—— discussion on epithelioma of naso-pharynx	53
—— discussion on fibro-angeioma of nasal septum	68
—— discussion on thickening of right cord, thought to be malignant.	70
—— discussion on absence of right choana	77
—— discussion on case of keratosis of larynx	86
PETERS (E. A.), case of chronic pharyngitis with polypi of uvula	22
Discussion (pp. 22, 23). Drs. Dundas Grant, Davis, Pegler, Westmacott, Peters (reply).	
—— a microscopic section of an angeio-fibroma	40
Discussion (pp. 40, 41). Dr. Pegler, Mr. Symonds (President), Drs. Grant, Smurthwaite, Jobson Horne, Dr. Peters (reply).	
—— a new nasal saw	96
Discussion (p. 96). Mr. Symonds, Dr. Tilley, Dr. Peters (reply).	
—— a case of epithelioma of the tonsils	111
Discussion (p. 112). Mr. C. J. Symonds (President), Mr. Betham Robinson.	
—— chronic osteitis of the frontal bone, with chronic sinusitis	112
Discussion (p. 113). Mr. Symonds (President), Dr. StClair Thomson.	
—— functional aphonia in a soldier after ague	112
—— discussion on tracheal cannula worn for incomplete bilateral paralysis of crico-arytenoid muscles during twenty-seven years	33
Pharyngitis (chronic) with polypi of uvula (E. A. Peters)	22
Pharynx: cancer (inoperable) of fauces, pharynx, tongue, and cervical glands treated with bacterial vaccine of <i>neoformans</i> (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107

	PAGE
Pharynx: shut off from naso-pharynx by fibrous tissue diaphragm (A. Logan Turner)	85
— syphilitic ulceration in (extensive), treated by calomel injections (Dundas Grant)	44
— tuberculosis of soft palate, pharynx, and epiglottis (C. Fox)	98
— ulceration of, unusual, probably specific (J. Dundas Grant)	33
— (wall of, posterior), ulceration and destruction of, with soft palate (A. Logan Turner)	85
— and larynx, ulceration of (J. B. Ball)	39
— and naso-pharynx, sclerotic hyperplasia of (A. Brown Kelly)	20
Polypi of uvula in chronic pharyngitis (E. A. Peters)	22
Polypus (bleeding) (nasal angioma), removed from floor of inferior meatus (W. H. Kelson)	72
— (nasal, recent) and sinusitis, with long-standing atrophic rhinitis (W. Hill)	24
POTTER (E. Furniss), case of abnormally large Eustachian cartilages projecting into the naso-pharynx to the extent of interfering with free nasal breathing in a girl aged sixteen	5
Discussion (pp. 6, 7). Drs. Donelan, W. Hill, F. Powell, Mr. C. J. Symonds (President), Dr. Hemington Pegler, Dr. Potter (reply).	
— case of fixation of right crico-arytenoid joint due to infiltration, probably malignant disease, in a woman aged fifty	49
Discussion (p. 50). Sir F. Semon, Dr. Grant, Mr. Waggett, Mr. Symonds (President), Dr. Potter (reply).	
— case of swelling projecting from left tonsil (retention cyst) in a girl aged twenty-three	72
— case of fixation of the right arytenoid in a woman aged forty, for diagnosis (shown by Dr. Davis)	88
Discussion (pp. 88, 89). Mr. Symonds (President), Dr. Davis.	
— discussion on malignant disease of base of tongue and epiglottis.	7
POWELL (H. Fitzgerald), discussion on immobile left cord	5
— discussion on Eustachian cartilages, projecting into naso-pharynx, preventing free nasal breathing	6
— discussion on multiple papilloma of larynx recurring after fifteen years	13
— discussion on glottic stenosis	81
<i>Proceedings</i> : alteration in size and printing of	28
Retention cyst, swelling, projecting from left tonsil (E. F. Potter)	72
Rhinitis (atrophic), case of (H. J. Davis)	63
— recent nasal polypus and sinusitis with long-standing atrophic rhinitis (W. Hill)	24
Rhinolith, specimen of (P. Watson Williams)	16
ROBINSON (H. Betham), case of fibro-angioma of nasal septum	68
Discussion (p. 69). Dr. Pegler.	
— discussion on sinus of chin	32
— discussion on case of ulceration of larynx and pharynx	40
— discussion on case of villous papillomatous growth in larynx, probably epithelioma	102
— discussion on epithelioma of palate	103
— discussion on case of epithelioma of tonsils	112
DE SANTI (Philip R. W.), man with malignant disease of the base of the tongue and epiglottis; question of operation	7
Discussion (pp. 7, 8). Sir Felix Semon, Dr. Furniss Potter, Dr. Lambert Lack, Dr. Scanes Spicer, Mr. C. J. Symonds (President), Mr. de Santi (reply).	
— woman with perverted action of the cords, shown at a previous meeting	8

	PAGE
Discussion (p. 9). Dr. de Havilland Hall, Dr. Scanes Spicer, Dr. Jobson Horne.	
DE SANTI (Philip R. W.), man aged eighty with sarcomatous growth of left nasal cavity; question of operation	9
Discussion (p. 10). Dr. Dundas Grant, Dr. Pegler.	
—— case of syphilitic granulomata and stenosis of the larynx, thyro-tomy performed	19
—— woman with immobile right vocal cord; previously shown May 5, 1905	73
Discussion (p. 73). Mr. Waggett, Dr. Watson Williams.	
—— woman, aged fifty, with malignant growth in naso-pharynx; question of operation	86
Discussion (pp. 86, 87). Mr. Baber, Mr. Symonds (President), Dr. Turner, Mr. de Santi (reply).	
—— child, aged twelve, with growth on left side of tongue	89
Discussion (p. 89). Dr. Davis, Mr. Symonds (President), Mr. de Santi (reply).	
—— discussion on specimen of rhinolith	16
—— discussion on swelling over left superior maxilla	23
—— discussion on tertiary syphilis of the larynx	24
—— discussion on paraffin injection for nasal deformity	66
—— discussion on thickening of right cord, thought to be malignant	70
—— discussion on glottic stenosis	81
—— discussion on large sessile tumour in left arytenoid region	88
Sarcoma: lobulated encapsuled tumour attached to posterior wall of naso-pharynx, microscopically sarcoma (A. Logan Turner)	84
Sarcomatous growth of left nasal cavity (P. R. W. de Santi)	9
Saw (nasal) (E. A. Peters)	96
Sclerosis, sclerotic hyperplasia of pharynx and naso-pharynx (A. Brown Kelly)	20
SEMON (Sir Felix), a case of tumour in the interarytenoid fold, probably tuberculous, in a man, aged about forty	10
Discussion (p. 11). Dr. Dundas Grant, Dr. de Havilland Hall.	
—— a case in which a tracheal cannula had been worn for nearly twenty-seven years on account of incomplete bilateral paralysis of the posterior crico-arytenoid muscles, which had remained unchanged all that time	32
Discussion (p. 33). Mr. Herbert Tilley, Dr. Peters.	
—— discussion on immobile left cord	5
—— discussion on malignant disease of base of tongue and epiglottis	7
—— discussion on multiple papilloma of larynx recurring after fifteen years	13
—— discussion on unusual ulceration of larynx (probably specific)	34
—— discussion on suppuration of frontal sinuses treated by intra-nasal methods	37
—— discussion on ulceration of left vocal cord	38
—— discussion on fixation of right crico-arytenoid joint due to infiltration, probably malignant	50
—— discussion on intrinsic laryngeal neoplasm	51
—— discussion on pedunculated growth of uvula	51
—— discussion on injection of cold paraffin for nasal deformity	54, 56
Septum (nasal) deviations: instruments for submucous resection of (H. Smurthwaite)	79
—— fibro-angioma of (H. B. Robinson)	68
—— swelling on upper part of, for diagnosis (C. Baber)	89
Sinus of chin (W. H. Kelson)	32
Sinusitis and recent nasal polypus with long-standing atrophic rhinitis (W. Hill)	24
—— (chronic) accompanying chronic osteitis of frontal bone (E. A. Peters)	112

	PAGE
SMURTHWAITE (Hugh), a patient shown in June, 1905, with thickening of right cord, thought to be malignant, exhibited again for further diagnosis	69
Discussion (p. 70). Mr. de Santi, Dr. StClair Thomson, Mr. Waggett, Dr. Pegler, Dr. Watson Williams, Dr. Smurthwaite (reply)	
—— instruments for submucous resection operation	79
—— discussion on sclerotic hyperplasia of pharynx and naso-pharynx	21
—— discussion on ulceration of left vocal cord	39
—— discussion on case of ulceration of pharynx and larynx	40
—— discussion on angeio-fibroma	41
—— discussion on case of atrophic rhinitis	63
—— discussion on paraffin injection for nasal deformity	66
—— discussion on glottic stenosis	81
Sondermann's suction apparatus (J. Dundas Grant)	45
Special General Meeting to consider Report of Council <i>re</i> Union of Medical Societies	28
SPICER (R. H. Scanes), multiple papilloma of the larynx in a man of forty-one, which had recurred after three years' treatment ending fifteen years ago	12
Discussion (p. 13). Dr. StClair Thomson, Sir F. Semon, Dr. Dundas Grant, Dr. Fitzgerald Powell, Dr. Jobson Horne	
—— a case of subacute osteomyelitis of frontal bone, with empyema of right frontal sinus, shown on May 5, 1905	13
—— case of intrinsic laryngeal neoplasm in a man aged seventy-three, shown at June meeting	50
Discussion (p. 51). Sir F. Semon, Dr. Pegler, Mr. Symonds (President), Dr. Grant, Dr. Scanes Spicer (reply).	
—— case of inoperable cancer of the fauces, the pharynx, the tongue, and the cervical glands that has shown marked amelioration after treatment for ten weeks with a bacterial vaccine of <i>neoformans</i>	105
—— remarks explanatory of the treatment, by Professor Sir A. E. Wright, F.R.S.	107
Discussion (pp. 107, 110). Mr. C. J. Symonds (President).	
—— discussion on malignant disease of maxillary antrum	3
—— discussion on malignant disease of base of tongue and epiglottis	8
—— discussion on perverted action of the cords	9
—— discussion on suppuration of frontal sinuses treated by irrigation only	48
—— discussion on injection of cold paraffin for nasal deformity	55
—— discussion on paraffin injection for nasal deformity	66
—— discussion on absence of right choana	71, 77, 78
—— discussion on ulceration of left cord	79
—— discussion on glottic stenosis	80
—— discussion on large sessile tumour in left arytenoid region	88
—— discussion on chronic frontal empyemata operated on by simplified Killian operation	97
Stenosis and syphilitic granulomata of larynx; thyrotomy performed (P. R. W. de Santi)	19
—— (glottic) (StClair Thomson)	80
STUART-LOW (W.), case of epithelioma of the naso-pharynx, with microscopic section	51
—— with Report by Dr. Wingrave	52
Discussion (p. 53). Mr. Symonds, Dr. Pegler.	
—— fixation of the left vocal cord in the cadaveric position, most probably due to adhesions fixing and dragging on the recurrent laryngeal nerve	113
Discussion (p. 114). Dr. H. J. Davis, Mr. Barwell, Mr. Stuart-Low (reply).	

	PAGE
STUART-LOW (W.), discussion on recent nasal polypus and sinusitis, with long-standing atrophic rhinitis	24
— discussion on chronic frontal empyemata operated on by simplified Killian operation	97
— discussion on mycosis of soft palate	104
Submucous resection operation, instruments for (H. Smurthwaite)	79
Suction apparatus, Sondermann's (J. Dundas Grant)	45
Suppuration of left frontal and left maxillary sinuses, closure of wound and irrigation (C. J. Symonds)	56
Supra-tonsillar fossa: pedunculated tumour, probably cystic, growing from the supra-tonsillar fossa (J. Dundas Grant).	3
Swelling on upper part of nasal septum, case for diagnosis (J. Donelan).	89
— over left superior maxilla (J. Dundas Grant)	23
— (ulcerated) in middle line of naso-pharynx and ulceration of left posterior fold of palate (H. W. Carson)	88
SYMONDS (Charters J), suppuration of frontal sinuses treated by irrigation only	46
Discussion (pp. 47-49). Dr. Vinrace, Messrs. Waggett, Tilley, Chichele Nourse, Drs. Spicer, Bennett, Grant, Mr. Symonds (reply).	
— suppuration of the left frontal and the left maxillary sinuses; closure of wound and irrigation	56
— carcinoma of the naso-pharynx	87
Discussion (p. 87). Dr. Grant, Mr. Symonds (reply).	
— discussion on malignant disease of maxillary antrum	2
— discussion on Eustachian cartilages, projecting into naso-pharynx, preventing free nasal breathing	6
— discussion on case of malignant disease of base of tongue and epiglottis	8
— discussion on sinus of chin.	32
— discussion on ulceration of pharynx, probably specific	35
— discussion on suppuration of frontal sinuses treated by intra-nasal methods	37
— discussion on case of ulceration of pharynx and larynx.	40
— discussion on angeio-fibroma	41
— discussion on extensive syphilitic ulceration in pharynx, treated by calomel injections	44
— discussion on laryngeal ulceration	44
— discussion on fixation of right crico-arytenoid joint, due to infiltration, probably malignant	50
— discussion on intrinsic laryngeal neoplasm	51
— discussion on pedunculated growth of uvula	51
— discussion on epithelioma of naso-pharynx	53
— discussion on sudden loss of voice	76
— discussion on absence of right choana	78
— discussion on ulceration of left cord.	79
— discussion on malignant growth in naso-pharynx	87
— discussion on case of fixation of right arytenoid, for diagnosis	88
— discussion on large sessile tumour in left arytenoid region	88
— discussion on growth on left side of child's tongue	89
— discussion on infiltration, with fixation, of right vocal cord	90
— discussion on three cases of syphilis in one family	92
— discussion on bilateral ulceration of posterior segments of vocal cords	95
— discussion on left recurrent paralysis and paralysis of soft palate associated with middle-ear disease and facial palsy	95
— discussion on new nasal saw	96
— discussion on epithelioma of palate	103
— discussion on mycosis of soft palate.	104
— discussion on case of inoperable cancer of fauces, pharynx, tongue, and cervical glands treated with bacterial vaccine of <i>neoformans</i>	107, 101

	PAGE
SYMONDS (Charters J.), discussion on case of palatal tumour of twenty years' duration	111
——— discussion on case of epithelioma of tonsils	112
——— discussion on case of chronic osteitis of frontal bone with chronic sinusitis	113
Syphilis, hyperplastic congenital, sketch of larynx and microscopic section of uvula from case of hyperplastic congenital syphilis (A. Brown Kelly)	68
——— extensive syphilitic ulceration in pharynx treated by calomel injections (J. Dundas Grant)	44
——— history of old specific infection in case of villous papillomatous growth, probably epithelioma (J. Dundas Grant)	101, 102
——— question of communication of three cases in one family from one to the other by oral infection (H. J. Davis)	91
——— secondary lesions of vocal cords (L. H. Pegler)	71
——— syphilitic granulomata and stenosis of larynx, thyrotomy performed (P. R. W. de Santi)	19
——— (tertiary) of larynx (G. C. Cathcart)	24
——— unusual ulceration of pharynx, probably specific (J. Dundas Grant)	33
 Telangiectasis (multiple) of skin and mucous membrane of nose and mouth, sketches of, shown by Dr. Brown Kelly	 22
THOMSON (StClair), a case of glottic stenosis	80
Discussion (pp. 80, 81). Dr. Spicer, Mr. Thorne, Dr. Grant, Dr. Powell, Mr. de Santi, Dr. Smurthwaite, Dr. StClair Thomson (reply).	
——— discussion on multiple papilloma of larynx recurring after fifteen years	13
——— discussion on tuberculous ulceration of nose healed under treatment	17
——— discussion on lupus of larynx and uvula, healed under treatment	18
——— discussion on thickening of right cord, thought to be malignant	70
——— discussion on absence of right choana	71
——— discussion on sudden loss of voice	76
——— discussion on infiltration, with fixation, of right vocal cord	90
——— discussion on left recurrent paralysis and paralysis of soft palate associated with middle-ear disease and facial palsy	94
——— discussion on epithelioma of palate	103
——— discussion on case of infiltration of left vocal cord	110
——— discussion on case of chronic osteitis of frontal bone with chronic sinusitis	113
THORNE (Atwood), discussion on sudden loss of voice	75
——— discussion on glottic stenosis	80
——— discussion on infiltration, with fixation, of right vocal cord	90
Throat (diseases), specimens and drawings illustrating various pathological conditions (A. Logan Turner)	81
Thyrotomy performed in case of syphilitic granulomata and stenosis (P. R. W. de Santi)	19
TILLEY (Herbert), four cases of chronic frontal empyemata operated on by a simplified Killian operation	96
Discussion (pp. 96, 98). Dr. Grant, Dr. Spicer, Mr. Stuart-Low, Mr. Herbert Tilley (reply).	
——— case of mycosis of the soft palate	103
Discussion (p. 104). Mr. Symonds (President), Mr. Stuart-Low.	
——— discussion on tracheal cannula worn for incomplete bilateral paralysis of crico-arytenoid muscles during twenty-seven years	33
——— discussion on suppuration of frontal sinuses treated by intra-nasal methods	36

	PAGE
TILLEY (Herbert), discussion on suppuration of frontal sinuses treated by irrigation only	47
—— discussion on new nasal saw	96
Tongue (base of) and epiglottis, malignant disease of (P. R. W. de Santi)	7
—— cancer (inoperable) of fauces, pharynx, tongue, and cervical glands treated with bacterial vaccine of <i>neoformans</i> (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
—— of child: papillary growth on left side of (P. R. W. de Santi)	89
Tonsil (left) swelling projecting from (retention cyst) (E. F. Potter)	72
Tonsils (epithelioma of) case of (E. A. Peters)	111
Tooth-plate removed from œsophagus (D. R. Paterson)	93
Trachea, incrustations of, reports of fatal termination of case (Dr. Law, Dr. Cathcart, Dr. Jobson Horne)	25, 26
Traumatic lesion of larynx (J. Dundas Grant)	3
Treasurer (honorary), report of, for year 1905	28
Tuberculosis of soft palate, pharynx, and epiglottis (C. Fox)	98
—— tumour in interarytenoid fold, probably tuberculous (Sir Felix Semon)	10
Tuberculous laryngitis (H. S. Barwell)	59, 60
—— ulceration of nose, healed under treatment (H. S. Barwell)	17
Tumour in interarytenoid fold, probably tuberculous (Sir Felix Semon)	10
—— of palate; twenty years' duration (J. W. Bond)	111
—— (lobulated, encapsuled), attached to posterior wall of naso-pharynx; clinically simple tumour, microscopically sarcoma (A. Logan Turner)	84
—— (pedunculated), probably cystic, growing from the supra-tonsillar fossa (Dundas Grant)	3
—— (sessile, large), in left arytenoid region (H. W. Carson)	88
TURNER (A. Logan), specimens and drawings illustrating various pathological conditions of the nose and throat: (1) larynx of a boy from a case of sudden death; (2) keratosis of the larynx; (3) pachydermia of the larynx; (4) diffuse papilloma of the larynx; (5) fibroma of the larynx; (6) a case of lobulated encapsuled tumour attached to the posterior wall of the naso-pharynx, which presented the clinical features of a simple tumour, but which microscopically proved to be a sarcoma; (7) ulceration and destruction of the soft palate and posterior pharyngeal wall; (8) a dense fibrous tissue diaphragm completely shutting off the pharynx from the naso-pharynx, with the exception of a small circular aperture placed mesially, which admitted the point of a surgical probe; (9) large cyst of the right ventricular band	81-86
Discussion (p. 86). Dr. Pegler (on case of keratosis of larynx).	
—— discussion on absence of right choana	78
—— discussion on malignant growth in naso-pharynx	87
Ulcerated swelling in middle line of naso-pharynx and ulceration of left posterior fold of palate (H. W. Carson)	88
Ulceration (tuberculous) of nose, healed under treatment (H. S. Barwell)	17
—— and destruction of soft palate and posterior pharyngeal wall (A. Logan Turner)	85
—— (unusual) of pharynx, probably specific (J. Dundas Grant)	33
—— of left vocal cord (W. H. Kelson)	38, 79
—— (bilateral) of posterior segments of vocal cords (L. H. Pegler)	95
Union of medical societies: see <i>Amalgamation</i> .	
Uvula, microscopic section of, from case of hyperplastic congenital syphilis (A. Brown Kelly)	68
—— pedunculated growth of (W. H. Kelson)	51
—— polypi of, with chronic pharyngitis (E. A. Peters)	22
—— and larynx, lupus of, healed under treatment (H. S. Barwell)	18

	PAGE
Vaccine (bacterial) of <i>neoformans</i> in treatment of case of inoperable cancer of fauces, pharynx, tongue, and cervical glands; marked amelioration (R. H. Scanes Spicer and Sir A. E. Wright, F.R.S.)	105, 107
Ventricular band (right), cyst of (A. Logan Turner)	85
VINEACE (Dennis), discussion on case of chronic thickening and deformity of epiglottis for diagnosis	11
—— discussion on suppuration of frontal sinuses treated by irrigation only	47
—— discussion on injection of cold paraffin for nasal deformity	55
Vocal cord (left): fixation in cadaveric position, most probably due to adhesions fixing and dragging on recurrent laryngeal nerve (W. Stuart-Low)	113
—— (left) immobile (W. H. Kelson)	4
—— infiltration of (H. S. Barwell)	110
—— ulceration of (W. H. Kelson)	38, 79
—— (right), immobile (P. R. W. de Santi)	73
—— infiltration of, with fixation (J. Dundas Grant)	89
—— thickening of, malignant? (H. Smurthwaite)	69
Vocal cords, perverted action of (P. R. W. de Santi)	8
—— (posterior segments of), bilateral ulceration of (L. H. Pegler)	95
—— swelling below anterior commissure of, causing dyspnoea, with deformity of epiglottis and indurated swelling of auricles (C. A. Parker)	100
—— (syphilis of), secondary lesions (L. H. Pegler)	71
Voice, sudden loss of (H. J. Davis)	75
WAGGETT (E. B.), a boy, aged seventeen, with absence of right choana. Discussion (pp. 71, 72). Dr. StClair Thomson, Dr. Davis, Dr. Spicer, Dr. Watson Williams	71
—— a case of absence of right choana. Discussion (pp. 77-79). Dr. Hill, Mr. Baber, Dr. Donelan, Dr. Spicer, Mr. Waggett, Dr. Dundas Grant, Dr. Pegler, Dr. Lack, Mr. Symonds, Dr. Davis, Mr. Waggett (reply).	76
—— discussion on swelling over left superior maxilla	23
—— discussion on recent nasal polypus and sinusitis with long-standing atrophic rhinitis	24
—— discussion on suppuration of frontal sinuses treated by irrigation only	47
—— discussion on fixation of right crico-arytenoid joint, due to infiltration, probably malignant	50
—— discussion on tuberculous laryngitis	60
—— discussion on thickening of right cord, thought to be malignant	70
—— discussion on immobile right vocal cord	73
WESTMACOTT (F. H.), discussion on chronic pharyngitis with polypi of uvula	23
—— discussion on swelling over left superior maxilla	24
—— discussion on tuberculous laryngitis	60
—— discussion on ulceration of epiglottis	62
WILLIAMS (P. Watson), specimen of a rhinolith. Discussion (pp. 16, 17). Mr. Cresswell Baber, Mr. P. R. W. de Santi, Dr. W. Jobson Horne, Dr. Watson Williams (reply)	16
—— discussion on case of chronic thickening and deformity of epiglottis for diagnosis	11
—— discussion on multiple papilloma of larynx recurring after fifteen years	13
—— discussion on tuberculous ulceration of nose, healed under treatment	17
—— discussion on recent nasal polypus and sinusitis with long-standing atrophic rhinitis	24
—— discussion on tuberculous laryngitis	61

	PAGE
WILLIAMS (P. Watson), discussion on ulceration of epiglottis .	62
——— discussion on case of atrophic rhinitis .	63
——— discussion on paraffin injection for nasal deformity .	66
——— discussion on thickening of right cord, thought to be malignant	70
——— discussion on absence of right choana .	72
——— discussion on immobile right vocal cord .	73
WINGRAVE (V. Wyatt), Report on Mr. Stuart-Low's case of epithelioma of naso-pharynx .	52
——— preparations illustrating Dr. Dundas Grant's case of laryngeal growth .	102
Discussion (p. 102). Dr. Wingrave, Mr. Butlin, Mr. Robinson, Dr. Dundas Grant (reply). See also <i>Grant</i> (J. Dundas): Villous papillomatous growth, etc.	
WRIGHT (Professor Sir A. E., F.R.S.), case of inoperable cancer of the fauces, the pharynx, the tongue, and the cervical glands that has shown marked amelioration after treatment for ten weeks with a bacterial vaccine of <i>neoformans</i> . Shown by Dr. Scanes Spicer. Remarks explanatory of the treatment by Professor Sir A. E. Wright, F.R.S.	107

